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**HANDBOOK OF
DISEASES OF THE EAR**

H A N D B O O K
OF
DISEASES OF THE EAR

For the Use of Students and Practitioners

BY

RICHARD LAKE, F.R.C.S. ENG.

SURGEON ROYAL EAR HOSPITAL

LECTURER ON PRACTICAL OTOTOLOGY, MEDICAL GRADUATES' COLLEGE

WITH THREE COLOURED PLATES

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INTRODUCTORY NOTE

THE writer takes this opportunity of expressing his indebtedness to Dr. C. Herbert Hall for his kindness in revising the manuscript, and also his appreciation of the trouble involved.

LONDON,
October, 1903.

CONTENTS

CHAPTER	PAGE
I. A BRIEF DESCRIPTION OF THE MORE IMPORTANT ANATOMICAL POINTS	I
II. THE GENERAL EXAMINATION OF THE PATIENT—THE SPECIAL EXAMINATION OF THE PATIENT	19
III. SPECIAL SYMPTOMS AND THEIR IMPORT—ESTIMATION OF THE ACUTENESS OF HEARING—GENERAL THERAPEUTICS: THE USE OF INSTRUMENTS	37
IV. THE EXTERNAL EAR: MALFORMATIONS, INJURIES, AND DISEASES—FOREIGN BODIES IN THE EXTERNAL MEATUS	67
V. DISEASES OF THE MIDDLE EAR: ACUTE	92
VI. DISEASES OF THE MIDDLE EAR: CHRONIC NON-SUPPURATIVE	110
VII. CHRONIC SUPPURATIVE DISEASES OF THE MIDDLE EAR	134
VIII. INTRACRANIAL COMPLICATIONS	163
IX. OPERATIONS	176
X. MALIGNANT DISEASE OF THE EAR	204
XI. DISEASES OF THE INTERNAL EAR—DEAF-MUTISM	206
XII. LIFE ASSURANCE	219
APPENDIX	222
INDEX	227

1

2

3

4

LIST OF ILLUSTRATIONS

FIG.	PAGE
1. Right Mastoid - - - - -	3
2. Inner Wall of Tympanum (Right) - - - - -	4
3. Vertical Section through Right Temporal Bone - - - - -	5
4. Preparation showing Attic and Cavum Tympani - - - - -	6
5. Tympanic Ring, and Ossicles at Birth - - - - -	7
6. The Ossicles (Right) articulated - - - - -	7
7. Dissection showing the Relations of the Chorda Tympani and the Ossicles - - - - -	8
8. Diagram of the Tympanic Membrane, showing various Normal and Artificial Points - - - - -	9
9. Dissection showing the Periosteum of the Eustachian Tube continuous with Membrana Propria of the Drum - - - - -	10
10. Tympanic Membrane and Anterior Half of Eustachian Tube, showing the Periosteum of the Latter continuous with the Substance of the Former - - - - -	11
11. Vertical Section through Right Temporal Bone - - - - -	12
12. Tegumentum Tympani removed, exposing Malleus and Suspensory Ligament - - - - -	13
13. Section through Sclerosed Mastoid Process - - - - -	14
14. Cellular Mastoid Process - - - - -	15
15. Section (Vertical) passing through the Cavum Tympani and Antrum, showing the two larger Ossicles <i>in situ</i> - - - - -	16
16. Aural Speculum - - - - -	27
17. Thudichum's Nasal Speculum - - - - -	31
18. Semi-diagrammatic Sketch of Posterior Nares, the Right (Patient's) Side being Normal - - - - -	33
19. Lucae's Tuning-fork (C) - - - - -	47
20. The Acoumeter - - - - -	51
21. Aural Forceps for cleansing the Ear with Cotton-wool Mops - - - - -	59
22. Siegel's Pneumatic Speculum attached to Delstanche's Masseur - - - - -	60
23. Lucae's Probe - - - - -	63
24. Grüber's Carrier for introducing Artificial Tympanic Membranes - - - - -	65

LIST OF ILLUSTRATIONS

FIG.	P.
25. Supernumerary Ossicles	-
26. Mal-development of External Ear	-
27. Malformation of External Ear	-
28. Papilloma of External Meatus	-
29. Hyperplasias and Exostoses	-
30. Calcareous Degeneration of the Tympanic Membrane	1
31. Diagram illustrating the Influence of Aspergoid Vegetations in the Naso-pharynx on Suppuration in Middle Ear	1
32. Perforation of Membrane in Posterior Superior Quadrant	1
33. Perforation of Membrane in Posterior Inferior Quadrant	1
34. Total Destruction of Membrane and Handle of Malleus	1
35. Professor Hartmann's Attic Cannula with Ball Syringe attached	1
36. Aural Polypes protruding from Meatus	1
37. Diagram showing the two larger Ossicles shaded to show the more usual Sites of Caries	1
38. Necrosis of the Labyrinth	1
39. Outer Surface of Temporal Bone of a Four-year-old Child, showing Necrosis over the Site of Mastoid Antrum	1
40. Preparation showing the Handle of the Malleus bound down by Cicatricial Tissue after cessation of Chronic Suppuration	1
41. Myringotomes, Blunt and Sharp Pointed	1
42. Incus Curette	1
43. Krause's Bone Punch for Removal of Outer Attic Wall	1
44. Showing Trephine Centres for Operations in Otitic Intracranial Lesions	1
45. Retractor	1
46. Mastoid Gouge	1
47. Chisel Points	1
48. Pus-searcher	1
49. Section of Left Temporal Bone showing the Cavity of the Antrum and its Relationship to the External Meatus. The Cavity is unusually large	1
50. Bone-forceps for Use in the Radical Mastoid Operation	1
51. Leukæmia. Section of Cochlea, Lowest Part	2
52. Section of Cochlea, higher up than Fig. 51	2
53. Section through Horizontal Semicircular Canal	2
54. Section of Apex of Cochlea, showing Leukæmic Clot commencing to Organize	2

CHAPTER I

A BRIEF DESCRIPTION OF THE MORE IMPORTANT ANATOMICAL POINTS

THE External Ear, or Pinna, is formed of a fibro-cartilage, thrown into folds of considerable irregularity in different persons, which folds are intended to deflect the sound-waves towards the external meatus. The small portion of cartilage in front of the external meatus, known as the tragus, has for its principal function that of preventing these deflected sound-waves from being lost. The pinna is covered with skin and subcutaneous tissue, and at its centre is folded upon itself, but the edges do not come into close apposition, a cleft being left in its upper part which is closed by fibrous tissues. A cartilaginous tube is thus formed, which is attached to a roughened surface on the outer part of the temporal bone, and forms the outermost portion of the external auditory canal or meatus. The auditory or external meatus, a cartilaginous and bony tube, is about $1\frac{1}{4}$ inches long; its external or cartilaginous portion has an approximate length of $\frac{3}{4}$ inch, on the anterior aspect of which are two vertical clefts in the cartilage, known as the fissures of Santorini. The inner or bony part of the canal, which averages in the adult $\frac{1}{2}$ inch in length, is continuous with the cartilaginous meatus, and closed at its innermost part by the tympanic membrane;

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The external meatus is lined with skin continuous with that of the pinna, and near its orifice are commonly found numerous fine hairs, while in its posterior surface are situated numerous small holes, the mouths of the ceruminous glands. These glands are chiefly confined to the cartilaginous meatus, but a few of smaller size are found within the osseous canal. The hairs serve to protect the tympanum by arresting the ingress of small bodies or

insects, while the wax or cerumen secreted by the glands creates a somewhat sticky surface, on which dust and small particles of matter adhere, and at the same time it binds together shed epithelial cells, which, together with the wax, are conveyed outwards by the movements of the lower jaw.

If the outer surface of the dried temporal bone be examined, there will usually be found at the upper and posterior part of the bony external meatus a small spinous process with a slight depression behind it (Fig. 1, *SH*). This spinous process is known as the spine of Henlé, or the

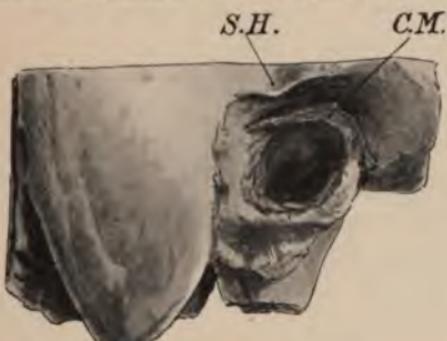


FIG. 1.—RIGHT MASTOID.

SH, Posterior meatal spine, or spine of Henlé; *CM*, cartilaginous meatus.

posterior superior meatal spine, and is a landmark of considerable importance in operations on the mastoid antrum; while from the malar process of the temporal bone two ridges are observed running backwards, the superior of which may be remembered as forming a useful guide to the upper limits of operative procedure on the antrum, unless it is desirable to enter the middle fossa of the skull. In some skulls the squamo-petrous suture is visible, and the two bones may even have remained separate, and suppuration within the mastoid may find an exit through such a fissure.

The Middle Ear, Tympanic Cavity, or Cavum Tympani, is an irregularly shaped cavity about $\frac{1}{4}$ inch in depth, $\frac{3}{4}$ inch in height, and $\frac{1}{2}$ inch in width. Its principal external boundary is the tympanic membrane, but the cavity extends in other directions beyond the membrane, chiefly upwards above the roof of the meatus, forming the so-called attic. The upper limit or roof is formed by a thin layer of bone, termed the tegmentum tympani. This bony plate is occasionally incompletely ossified, and the spaces left in the bone are merely filled in by fibrous tissue, so that in these

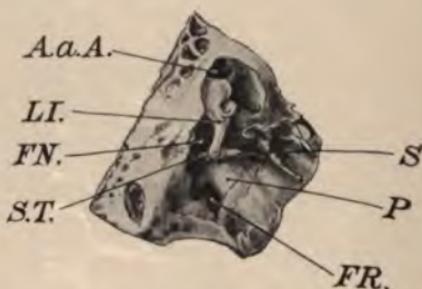


FIG. 2.—INNER WALL OF TYMPANUM (RIGHT).

Aa.A., Aditus ad antrum; *LI.*, long process of incus; *FN.*, Fallopian canal; *ST.*, stapedius tendon; *S*, stapes; *P*, promontory; *FR.*, fenestra rotunda.

instances there is between the middle ear and dura mater only a thin layer of muco-periosteum, and through the deficiencies thus left septic matter from the middle ear may easily obtain entry into the middle fossa of the skull. The floor of the cavity consists of a plate of bone, which at the same time partly forms the roof of the hollow in the lower part of the temporal bone, which receives the bulb of the jugular vein. Its anterior and posterior walls are made up of portions of the temporal bone. On the inner wall of the tympanic cavity are found from above downwards the following important structures (Fig. 2): A prominent ridge

of bone is observed above and behind, running across the posterior half. This is the Fallopian canal, which in the recent state contains the facial nerve. Anterior to this elevation is a small hollow bony projection, through which passes the tendon of the tensor tympani muscle. Below the Fallopian canal is seen an oval depression—the fenestra

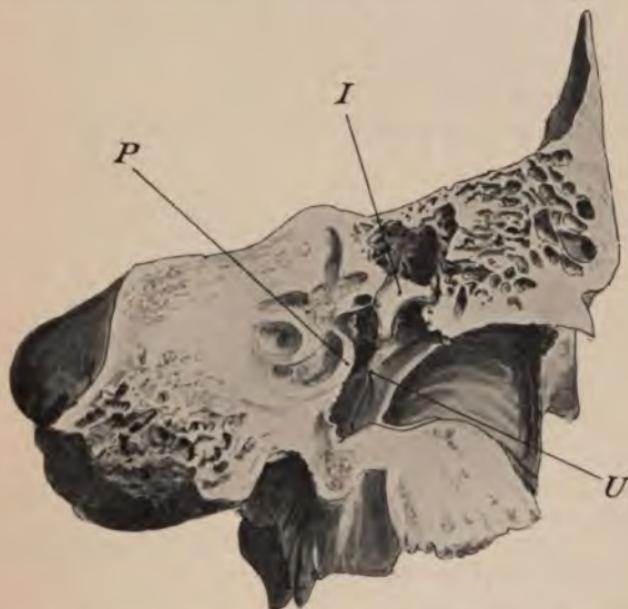


FIG. 3.—VERTICAL SECTION THROUGH RIGHT TEMPORAL BONE.

U, Umbo; *I*, incus; *P*, promontory.

ovalis—which in the living body receives the footplate of the smallest of the ossicles—the stapes—its edges being connected with the surrounding bone by ligamentous tissue; and at the lower and posterior part of the inner wall is another depression, irregular in shape, known as fenestra rotunda. The internal wall of the cavity projects prominently outwards between these fenestræ, and to this

elevation, formed by the first part of the lower end of the cochlea, the title of the promontory has been given. From the posterior wall, at the same level as the *fenestra ovalis*, issues the tendon of the *stapedius* muscle from a small conical bony process termed the *pyramid*. This process can only be seen in rare instances during life, and then through a large posterior perforation of the drum with an unusually straight meatus. The anterior wall of the cavity is characterized by an oval opening—the internal orifice of the *Eustachian* tube.

The *Attic* is that portion of the tympanic cavity which

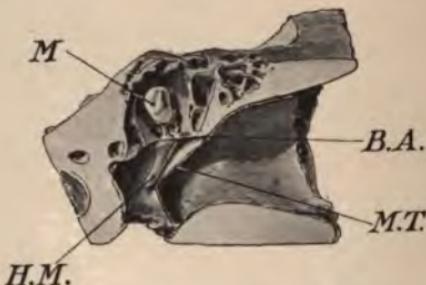


FIG. 4.—PREPARATION SHOWING ATTIC AND CAVUM TYMPANI.

MT., Tympanic membrane; *HM*, handle of malleus; *BA.*, base of attic; *M*, head of malleus, surrounded by irregular cellular spaces caused by reduplications of the mucosa.

lies above an imaginary line drawn horizontally through the short process of the malleus, and contains the head of the malleus, with the body and short process of the incus.

The walls of the tympanic cavity are clothed in the recent state by a thin muco-periosteum, continuous on the one side with that of the *Eustachian* tube and on the other with that lining its large accessory cavity, the *antrum*. The middle ear is filled with air, and communicates with the external atmosphere through the *Eustachian* tube.

The contents of the tympanum are the ossicles—the

malleus, incus, and stapes—the chorda tympani, tensor tympani and stapedius tendons, and some small vessels and nerves.

The Ossicles.—The malleus, which is the largest of these little bones, is divided anatomically into a head, neck,

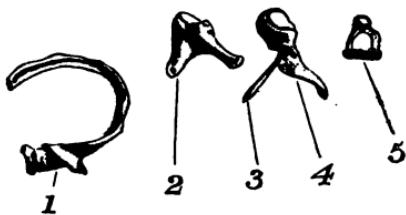


FIG. 5.—TYMPANIC RING, AND OSSICLES AT BIRTH.

1, Tympanic ring; 2, incus; 3, processus gracilis; 4, malleus; 5, stapes.

and handle. The head articulates with the second largest bone, the incus. Below the head is a constricted portion—the neck—which passes into the long handle. At the junction of the handle with the neck are seen two processes of



FIG. 6.—THE OSSICLES (RIGHT) ARTICULATED.

The stapes has fallen out of place; it should be almost at a right angle to the long process of the incus.

bone, one projecting outwards and forwards, known as the short process, or processus brevis; the other directed forwards and inwards towards—and in the foetus through—the Glaserian fissure, the processus gracilis. The latter is represented in the adult by a minute point of bone, to which is attached the anterior ligament. The handle is

directed nearly vertically downwards, and is intimately connected with the *membrana tympani*. The head of the malleus is attached to the roof of the tympanum by a ligament termed the suspensory ligament (Fig. 12). The incus consists of a body and two processes, the body articulating with the head of the malleus, to which it is united by a capsular ligament. The short process projects almost horizontally backwards, and articulates with the floor of the passage from the tympanum to the antrum. The long process descends parallel with the handle of the



FIG. 7.—DISSECTION SHOWING THE RELATIONS OF THE CHORDA TYMPANI AND THE OSSICLES.

CT, Chorda tympani; S, stapes; ST, stapedius tendon; FR, foramen rotundum.

malleus to the level of the centre of the *fenestra ovalis*, where it articulates with the head of the stapes, to which it is attached by a capsular ligament. The third ossicle, or stapes, which closely resembles a stirrup, consists of a foot-plate, two *cruræ*, a neck, and a head. The footplate articulates with the inner edge of the *fenestra ovalis*, to which it is attached by an annular ligament. Of the *cruræ*, the anterior is straighter and shorter than the posterior. To the posterior part of the neck of the stapes is attached the tendon of the stapedius muscle. The footplate of the stapes moves hinge-like in the oval window, and on account

of the greater laxness of the annular ligament in the anterior part, its greater range of movement lies anteriorly. The chorda tympani nerve (Fig. 7) issues from the posterior wall of the tympanum, and crossing obliquely forwards, passes external to the long process of the incus, behind the handle of the malleus and above the tendon of the tensor tympani, and leaves the tympanum in company with the anterior ligament of the malleus by way of the Glaserian fissure. The ossicles, tendons, and chorda tympani nerve receive a covering of mucous membrane from the lining membrane

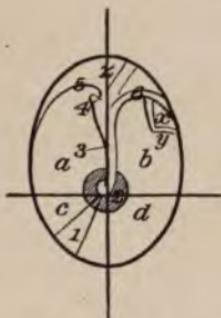


FIG. 8.—DIAGRAM OF THE TYMPANIC MEMBRANE, SHOWING VARIOUS NORMAL AND ARTIFICIAL POINTS.

1, Cone of light; 2, umbo; 3, handle of malleus; 4, short process; 5, anterior ligament of membrane; 6, posterior ligament of membrane; *ac*, anterior segment; *a*, anterior superior quadrant; *c*, anterior inferior quadrant; *bd*, posterior segment; *b*, posterior superior quadrant; *d*, posterior inferior quadrant; *z*, Shrapnell's membrane; *y*, stapes; *x*, long process of incus.

of the cavity; this disposition of the mucous membrane forms irregular folds and bands within the cavity.

The Tympanic Membrane, or Drum, is a fibrous or periosteal membrane which, from the obliquity of the canal, faces downwards and forwards, forming an angle of 140° with the superior and posterior walls, and an acute angle of 30° with the anterior. Its general shape is oval, the longer diameter being the vertical one, and it presents a general

concavity outwards. The handle of the malleus running almost directly downwards to the centre of the membrane divides it into two unequal portions, the anterior of which is the larger. The concavity of the drum is deepest at the tip or free end of the handle. The centre of this small and deeply-depressed area has been styled the *umbo*.

The membrana tympani itself consists of three layers—an external cutaneous, continuous with the skin of the external

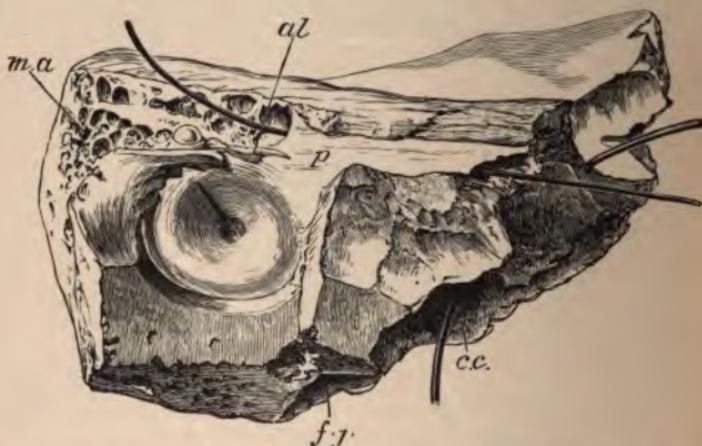


FIG. 9.—DISSECTION SHOWING THE PERIOSTEUM (*p*) OF THE EUSTACHIAN TUBE CONTINUOUS WITH MEMBRANA PROPRIA OF THE DRUM.

cc., Carotid canal (with probe); *f.j.*, jugular fossa; *al*, anterior ligament of malleus; *ma*, mastoid antrum. The second probe is in the Eustachian tube.

meatus, a middle layer of fibrous structure, and an internal layer of mucous membrane identical and continuous with that of the tympanic cavity. The middle layer, known as the membrana propria, has radiating and circular fibres, the radiating passing from the periosteum of the handle of the malleus to the periphery, while the circular are found only in the outer portion. The fibrous layer is inserted, as it were, into a firm ring of fibrous tissue, which is received into a bony groove at the inner extremity of the external

meatus, termed the *sulcus tympanicus*. This groove is situated almost within the tympanic cavity, as seen in the dried bone. Through this fibrous groove the *membrana propria* is continuous with the periosteum of the external meatus on the one side (Fig. 9), and with that of the tympanic cavity and the Eustachian tube on the other (Figs. 9, 10 and 15). The handle of the malleus is intimately connected with the fibrous layer of the drum at its lowest



FIG. 10.—TYMPANIC MEMBRANE AND ANTERIOR HALF OF EUSTACHIAN TUBE, SHOWING THE PERIOSTEUM OF THE LATTER CONTINUOUS WITH THE SUBSTANCE OF THE FORMER.

part, but in its upper two-thirds the fibres of the drum for the most part pass external to it, thus permitting a certain amount of mobility of the external part of the drum without a corresponding movement on the part of the malleus. At the inner extremity of the external meatus the wall is deficient above. The space which is left is termed the notch of Rivini, and in the recent state is bridged over by irregularly interlacing bands of fibrous tissue. This portion

of the drum forms the so-called Shrapnell's membrane, or *membrana flaccida*, and is not actually part of the tympanic membrane.

The tympanic membrane is divided, for purposes of

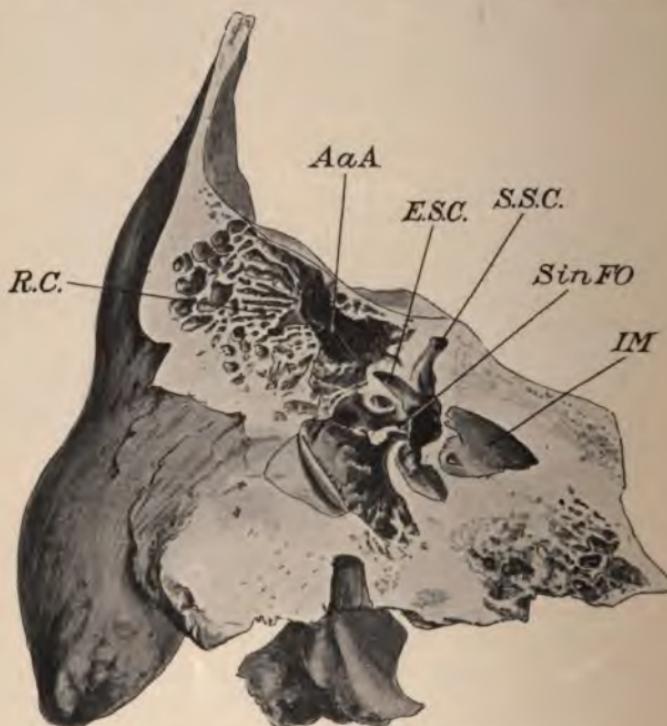


FIG. II.—VERTICAL SECTION THROUGH RIGHT TEMPORAL BONE.

AaA, Aditus ad antrum; *RC*, radiating cells (round antrum); *ESC*, external semicircular canal; *SSC*, superior semicircular canal; *S in FO*, stapes in fenestra ovalis; *IM*, internal meatus.

description, by an imaginary line drawn through and in continuity with the handle of the malleus, into an anterior and posterior segment. These segments are subdivided by a line drawn at right angles to the former through the tip of the malleus, thus dividing each segment into two, which

are known respectively as the anterior superior, anterior inferior, posterior inferior, and posterior superior quadrants (Fig. 8).

Besides the handle of the malleus, the following features are to be observed by visual inspection of the drum :

In appearance, the membrane is in health pearly gray, but considerable variations are observed within physiological



FIG. 12.—TEGMENTUM TYMPANI REMOVED, EXPOSING MALLEUS AND SUSPENSORY LIGAMENT (SM).

limits. At the upper part of the handle, projecting forwards and outwards, is a small bony process. This is the processus brevis, or short process of the malleus, which in the healthy subject appears white. Above this point lies Shrapnell's membrane, while from it run two curved bands with their concavities downwards, the anterior and posterior ligaments of the membrane, which form the upper margin of the drum, and limit Shrapnell's membrane below. There is

seen spreading forwards and downwards triangularly from the umbo a light reflex, called the cone of light, which owes its origin to the peculiar concavity of the normal drum, for light can only be reflected back to the observer from this small triangular area of the drum; its extent should be from the umbo to the periphery.

The Antrum, also called the mastoid or tympanic antrum,



FIG. 13.—SECTION THROUGH SCLEROSED MASTOID PROCESS.

is the most regular of the pneumatic or air cells found in the mastoid process. It is situated posterior to and at a slightly higher level than the main cavity of the tympanum, with which it is connected by a passage, the iter, or *aditus ad antrum*. It is formed in the foetus by the junction of the squamous and petrous portions of the temporal bone, and exists before the mastoid process is developed. Its size in the foetus and child is proportionately very large. Thus,

excepting from its situation in the adult, the term ' mastoid antrum ' is not anatomically correct. The aditus, or passage into the antrum, opens into the tympanic cavity at the upper part of its posterior wall, the facial nerve passes from before backwards at the tympanic end of its floor, and the external, or horizontal semicircular, canal makes a projection forwards on its inner wall. The antrum in the fœtus is situated superior to, but on a slightly posterior



FIG. 14.—CELLULAR MASTOID PROCESS.

plane to, the tympanic cavity ; but at the end of childhood, about the age of nine years, it has come to occupy relatively the same level at which we find it in the adult. The antrum is connected with the other pneumatic cells of the mastoid process. There are, in addition to the antrum, two groups of these cells, which are of importance on account of their position, one being situated at the inner part of the roof of the external meatus, termed the ' border

cells,' which, if not connected directly with the attic, are connected with the antrum; the other group, when present, extends upwards and forwards from its posterior root into the base of the zygomatic process. The orifice of the aditus is in a direct line with the tympanic orifice of the Eustachian tube; so that if a probe be passed up the Eustachian tube, after crossing the tympanic cavity it strikes and enters the aditus. From this it will be seen that the antrum is not



FIG. 15.—SECTION (VERTICAL) PASSING THROUGH THE CAVUM TYMPANI AND ANTRUM, SHOWING THE TWO LARGER OSSICLES IN SITU.

ct, Chorda tympani; *tt*, tensor tympani; *sl*, suspensory ligament of malleus; *p*, periosteum of Eustachian tube.

situated so deeply from the surface as the tympanum itself; and it is of great importance to remember this fact when performing the radical operation of mastoidectomy, as the inner wall of the tympanic cavity appears to, and does, lie at a greater depth from the surface than does the inner wall of the antrum. The antrum is placed about 0.6 inch from the surface, and is separated from the sigmoid groove by about 0.48 inch.

The Eustachian Tube is $1\frac{1}{2}$ inches long, is directed

downwards, forwards, and inwards, and, like the external meatus, consists of a bony inner portion, approximately $\frac{1}{2}$ inch in length, and an outer cartilaginous portion. The narrowest part of the Eustachian tube is at the junction of the two parts, and is termed the *isthmus*. The cartilaginous canal opens into the naso-pharynx at a level slightly above that of the hard palate. The posterior part of the cartilaginous wall projects inwards, forming an eminence called the *posterior lip* of the *ostium*. Just within this orifice, and beneath some involuntary muscular fibres, is normally found a small quantity of fat, which assists in keeping the sides of the tube in apposition. The tube itself is lined with ciliated epithelium. Behind the *ostium* is a deep depression in the side of the naso-pharynx, termed the *fossa of Rosenmüller*, into which the Eustachian catheter may be passed in mistake for the entrance of the Eustachian tube. The tube itself is open during the process of deglutition, which enables the air within the *cavum tympani* to maintain an equal pressure with that of the atmosphere; and it is upon a knowledge of this physiological fact that the process of inflating the tympanum, which goes by the name of *politzerization*, is founded.

The Mastoid Process is not present at birth, and does not acquire its typical shape until the end of the third year. In the adult it varies much in structure, but its general shape is much the same, being roughly triangular, with the apex downwards. It contains, besides the antrum, certain irregularly distributed pneumatic cells, together with a certain amount of *diploë*. The structure of the mastoid may vary within wide limits, being, on the one hand, composed entirely of cells (Fig. 13), and, on the other hand, formed almost entirely of dense bone (Fig. 14). When the mastoid process is formed almost exclusively of cells, the majority are pneumatic; and in these instances there is one cell which

is fairly constantly present, and is found at the lower and inner aspect of the mastoid process just above the groove for the digastric muscle. To the presence of this cell is due the fact that, in certain inflammatory conditions of the mastoid, pus is enabled to find its way into the digastric groove, and onwards into the deep structure of the neck. At other times the general structure of the process resembles that of the diploë.

CHAPTER II

THE GENERAL EXAMINATION OF THE PATIENT

The Patient's Previous History.

INQUIRY should be first directed to the family history of the patient and to his previous illnesses, more especially with regard to the various exanthemata, and any relationship suggested by the patient between the first occurrence of the aural trouble and any such general disorder made note of. In the event of no such information being forthcoming, careful cross-examination, with reference particularly to scarlet fever and measles and the first onset of deafness or discharge from the ear, will often throw a good deal of light on the nature and duration of the disease. Inquiry should also be made as to whether the patient in childhood had been subject to attacks of earache, for cases will not infrequently present themselves in which there is more or less destruction of one or both tympanic membranes, or other strong evidence of previous aural suppuration, and yet the patients deny any knowledge of discharge from the ear, but distinctly remember that they frequently had ear-ache in early childhood, the presence of the discharge having been either overlooked by them and their parents or completely forgotten.

If there is deaf-mutism, it is very important, from the

point of view of prognosis, that the earliest sign of the deficiency be accurately determined, such as whether the child had ever shown any signs of hearing or uttered any articulate cry, or whether the child had already commenced to speak, if only one or two words, and that after some severe illness or accident the hearing power was lost, and with it that of articulate speech. Cases of deaf-mutism subsequent to disease in early childhood require to be divided with great care into those dependent on intracranial lesions, such as those following meningitis, and into those due to a probable special inflammatory condition of the middle ear, causing temporary deafness. The commonest origin of this latter form is secondary involvement of the middle ear during an attack of bronchopneumonia. In these cases, when the child has been thought to have suffered from meningitis, even if some of the serious symptoms of meningitis have been present, the prognosis is much more hopeful than in those cases due to genuine meningeal trouble.

Previous illnesses, it is necessary to bear in mind, often have a distinct influence on the ear, particularly should the presence or absence of hereditary or acquired syphilis be ascertained. When this disease is hereditary, and deafness presents itself as a tertiary lesion, it usually begins in early life, from the age of twelve upwards, but it may be delayed until early adult life, and then generally commences after the appearance of interstitial keratitis. It is rapid in its course, and the influence of the treatment adapted to the keratitis apparently affects the course of the aural disease only slightly. Hutchinson's teeth and any affections of the nasal bones, as well as a history of snuffles, must be searched for.

Gout, rheumatism, and influenza have an effect upon the ear in a certain proportion of cases. The most frequent manifestation of gout is to be found in an eczematous condi-

tion of the external meatus; in cases of chronic middle-ear catarrh the tendency to tinnitus and vertigo is greatly increased if the patient has a gouty dyscrasia.

In rheumatism the remedies administered for its cure will frequently cause tinnitus and deafness, the most important of these being the salicylates; and it has been noticed that where they cause aural trouble there is already a tendency to diseases of the ear.

Influenza may be followed by haemorrhagic otitis media, by suppurative otitis media, and by isolated abscess in the mastoid, and these in turn may give rise to any of the intracranial lesions which follow on suppurative disease of the middle ear. In other cases non-suppurative catarrh may be set up, or severe nerve deafness itself may follow.

Residence in the tropics, especially if the patient be also subject to attacks of malarial fever, is often found to have an important bearing on the progress of the non-suppurative diseases of the middle ear. It also has a tendency towards the production of an altered secretion of the ceruminous glands of the external ear, causing an undue accumulation of cerumen.

Ague, which in England is now certainly very rare, but is still to be found, especially in the Fen Country and in the low-lying lands of Kent and Essex, has an equally deleterious effect upon the middle ear to that which malaria has in the tropics.

Climate is also indirectly responsible for much aural disease, too much moisture in the atmosphere inducing catarrhal states of the nose and naso-pharynx, thus indirectly affecting the ear through extension of the inflammatory processes up the Eustachian tube. The inhabitants of the basins of rivers and fen-lands and those living on clayey soils are much more likely to suffer from adenoids than those living in higher and dryer localities. These vegetations lead to diminished aeration of the ear, as well

as catarrhal changes, and expose the individual to a greater liability to suppurative processes in the middle ear.

Unhygienic surroundings and faulty nutrition appear to have only an indirect effect on the ear, but it is of interest to remember that atrophic rhinitis is chiefly met with in those classes exposed to bad environment, and of these cases a proportion is complicated with ear disease.

Habits and the daily occupation must be also considered as to their influence on the individual. Any tendency to excess in the consumption of alcohol or of tobacco, though rarely of themselves likely to be the primary cause of an aural complaint, may certainly be the means of accentuating it, if present. Those occupations where workmen are employed in tunnelling predispose to ear affections, if it be necessary, under such conditions, to use chambers of compressed air in caissons. In the case of workers in compressed air there is reason to believe that if due precautions are taken no evil effects accrue so long as the individual subjected to the increased atmospheric pressure has a relatively normal ear, which includes a patent Eustachian tube and an unobstructed nose. Riveters, who are exposed to almost continuously repeated sounds of more or less one pitch, are especially liable to aural complaints; and with men similarly employed the continuous clang of the metal causes a severe and intractable variety of nerve-deafness, and this does not appear to be entirely dependent upon previous slight aural disease, though middle-ear deafness doubtless predisposes to it. Ordinary commercial life cannot be said to cause deafness, but great mental strain and prolonged anxiety will materially exaggerate any existing middle-ear deafness. This effect naturally depends largely on the temperament of the individual.

Injuries.—Certain injuries act directly on the tympanic membrane, causing rupture of the drum. Of these, direct

blows on the ear, by compressing the air in the external meatus, are the commonest causes. Sudden compression of the air, such as that caused by loud explosions, in the near vicinity of the patient has been known to cause a like result, but it is supposed by most authorities that this would not have occurred had the drum been normal, though this opinion is ably contested by Hartmann. The membrane is sometimes injured by patients attempting to remove wax by the help of hairpins, etc., which are inadvertently thrust through the membrane, an accident which has happened to surgeons in ill-directed attempts to remove a foreign body without proper illumination of the meatus.

The internal ear may also be similarly injured by the effects of concussion, the most frequent causes being loud noises close to the ear, such as are produced by the firing of large ordnance when the individual is standing near to and on a level with or slightly beyond and to the side of, the mouth of the piece. Fracture of the base of the skull, if the fracture passes through the labyrinth, will cause deafness, though loud subjective noises may afterwards, in the event of recovery, be a distressing feature in the case; concussion of the brain and severe blows on the mastoid may cause deafness through concussion of the labyrinth.

The Patient's Present State.

The next step in the examination of the patient consists in making a careful survey of his present condition.

The Aspect of the Patient.—From the patient's appearance valuable information is obtained. Should the patient be young, and there is reason (there usually is in aural patients at this period of life) to suspect the presence of adenoid vegetations, the facial aspect must be noted. There are two physiognomies associated with nasal

obstruction in children. In the one there is a sleepy, and often vacant look, which, in its most pronounced type, denotes the so-called aprosexia of Guye. Here the expression lacks intelligence, the mouth is open, the eyes wide apart, the bridge of the nose broad and low, with frequently a vein running transversely across it; these patients have great difficulty in concentrating the attention and maintaining it fixed on any special subject. In the other class the nose is narrow and pinched, the alæ collapsed, and the mouth open. Between these extremes any intermediate condition may be met with, but the mouth is always open at night. The patients, with few exceptions, snore, though the mouth may not be noticeably open during the daytime. The palate is generally highly arched, often irregularly so, and the alveolar arch is contracted anteriorly; the front teeth project outwards, and not uncommonly the inferior maxilla is, as a whole, badly developed, so that the lower incisors come into contact with the posterior surface of the upper set, which in consequence often assumes a more or less horizontal direction. The faucial tonsils may or may not be enlarged; should there be nasal obstruction, granular pharyngitis will always be present.

In adults the tendency to mouth-breathing should be carefully observed, and the state of the patient's lips will often afford a clue, as in mouth-breathers the muco-cutaneous surface of the lower lip is drier than in nose-breathers; patients will often deny that they are mouth-breathers when it is quite evident that during intervals of speaking their lips have been obviously apart. As corroborative evidence of mouth-breathing in children, besides snoring, there is great restlessness during sleep, night terrors, and complaints of thirst during the night; in adults, the patient, on waking in the morning, has often either a dry tongue or a disagreeable taste in the mouth.

Facial paralysis, if present even to the slightest extent, will be easily remarked. Any tendency on the part of the patient to look at the mouth of the examiner should be observed; to detect this habit it is a good plan to practise speaking with as little lip movement as possible.

From the patient's voice there is also something to be learned. The dead and so-called nasal voice of adenoids and obstruction is easily recognised and never forgotten. Neither is the inability which accompanies this condition to pronounce distinctly certain letters, especially M. Patients with chronic non-suppurative disease of the middle ear, even when they are suffering from a severe degree of deafness, usually speak in a quite low tone, whilst elderly people, whose deafness is largely attributable to old age, not infrequently shout. Sufferers from nerve deafness have in most cases a dull, monotonous delivery. Malformations of the ear, unequal projections of the auricles, the presence of new growth, and disfigurements from old otohæmatomata, will be observed on superficial examination.

The Patient's Present History and the Duration of the Disease.

The length of time that the patient has suffered from hardness of hearing, tinnitus, or discharge, should be carefully inquired into, and leading questions will often cause him to considerably antedate his original statements. The importance of this history in non-suppurative diseases of the middle ear lies in the influence it has upon prognosis. In acute suppurative disease of the ear the patient will give a much more correct history than if it is chronic and dates from early childhood; in all suppurative conditions, however, the presence of pain, headache, local neuralgias, giddiness, sickness, nausea, or facial paralysis, as well as definite cerebral symptoms, such as loss of memory, especially for names and places, should be most carefully inquired for.

In non-suppurative affections questions should be directed towards the presence or absence of adenoids, nasal obstruction, complaints of giddiness and pain, as well as whether or not the patients hear their own voices better than extraneous sounds, and, finally, whether hearing is better during noise than quiet.

THE SPECIAL EXAMINATION OF THE PATIENT

In all cases of ear trouble, after the patient's history has been completed, the ears should be examined before proceeding to test the powers of hearing. For, should the meatus be blocked by a ceruminous plug, any examination with the tuning-fork would be useless.

In the examination of the ear the head-mirror should be invariably used. For convenience the ordinary rhinolaryngological mirror with a focus of 8 inches is used, but for finer work, and to obtain a more definite detailed view, a mirror having a focus of about $4\frac{1}{2}$ inches will be found superior. It is better, especially in towns, to use artificial light, but, when available, sunlight reflected from a white cloud supplies thoroughly serviceable illumination.

The external ear is rapidly examined with the eye, as well as with the finger and thumb, to detect any thickening or abnormal condition of the pinna. The entrance of the meatus, its size, as well as any obvious obstruction or the existence of discharge, must be reviewed. If there is discharge or pain complained of, the surface of the mastoid process should be palpated, and at the same time any tendency to redness or puffiness of the skin in this region looked for, as well as any obliteration of the post-auricular cleft; the relative projection of the auricle, as compared with its fellow, is an important sign. After gentle palpation, firm pressure should be made over the whole mastoid process, especially over the site of the mastoid antrum—

that is to say, a spot close behind the auricle, and at a slightly higher level than the external meatus. The elicitation of pain here or at any other portion of the mastoid may be considered periosteal in origin if the pressure required is slight, but due to disease within the bone if the

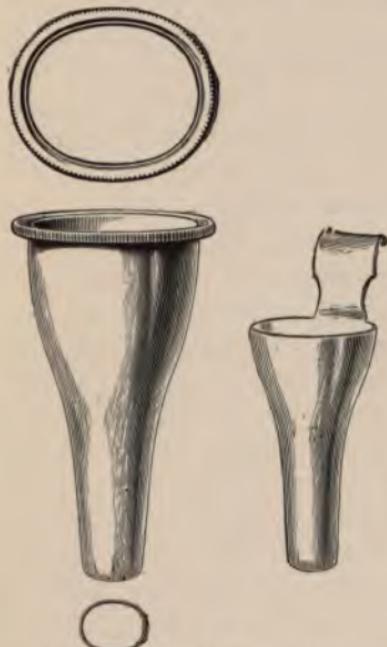


FIG. 16.—AURAL SPECULUM.

The left-hand wood-cut represents the largest-sized Grüber's speculum, with a view of the two extremities, showing their ovoid form. The wood-cut on the right is a Grüber's speculum cut down to enable the surgeon to operate more easily on the drum.

pressure required be firm. Again, in periosteal trouble tenderness will be general rather than local. The presence also of any subcutaneous collection of fluid, of an enlarged gland, or discharging sinuses in this locality, cannot be missed if this scheme of examination be carried out.

Having now obtained all the information possible by

these means, a careful examination is made of the meatus and tympanic membrane through a speculum. A form of speculum which is entirely satisfactory is that of Grüber. It is made of metal, blackened on the inside, and is elliptical in section. The speculum chosen should be the largest which will enter the meatus easily. In introducing the speculum, the pinna is taken between the finger and thumb and drawn gently backwards, outwards, and upwards, thus straightening the meatus and enabling the observer to obtain the best possible view of its interior and of the tympanic membrane. Having inserted the speculum, the following points are to be observed: Any obstruction of the canal, whether this be due to substances within it, as accumulated cerumen, or caused by a projection of the meatal wall, as by abscess, exostosis, or new growth; whether the obstruction be due to contraction of its lumen, either cicatricial or otherwise. The colour of the normal meatus is that of ordinary skin, and any variation therefrom should be noted: if it be red from inflammation, ulcerated, as occasionally happens in secondary syphilis, or if it be unusually smooth, white, and glistening, as in oto-sclerosis, or whether its surface exhibits spots of a black, slate, red, or white tint due to the presence of fungi. The existence of discharge, or a dry and scaly condition of its walls, must not be missed. If the lumen of the meatus is not absolutely free from obstruction steps must be taken to render it so, as well as to remove every trace of discharge or moisture before proceeding to an examination of the fundus. The tympanic membrane is first observed with the patient's head erect, and afterwards with the head inclined towards the opposite shoulder, in order to enable the upper part of the drum, together with Shrapnell's membrane and the meatal roof, to come into view.

It cannot be too firmly impressed upon students of aural surgery that, under no condition whatever, should an exami-

nation of the tympanic membrane be carried out so long as there is the slightest trace of moisture within the canal. Indeed, an opinion ought not even to be formed until all moisture has been removed from the ear, though this cleansing is chiefly necessary in suppurative conditions. The presence of offensive pus would usually justify the assumption that the drum was perforated; but it is not until the ear has been thoroughly cleansed and dried that the actual state of the fundus can be accurately determined, even by the most experienced aurist.

The inner extremity of the external meatus is normally closed by the *membrana tympani*, which is placed with its outer surface looking both downwards and outwards; it is this obliquity which enables the skilled examiner to estimate any alterations in the general contour of the drum. In some instances the external meatus is so straight, and its calibre so large, that a fair view of the membrane may be obtained without the use of the speculum and reflected light. In others the meatus is so small, and its natural curves so exaggerated, that only a small part of the membrane can be viewed, even by the most skilled aurist. (For description of the membrane see pp. 9-14.)

The attention should now be directed towards observing the colour, transparency, and general characteristics of the drum; the direction and apparent shape of the handle of the malleus; the direction, size, shape, and integrity or otherwise of the cone of light; the existence of perforations or depressions in the membrane; of patches of thickening or calcareous deposits, of attenuated areas in the drum, or of any swelling or bulging of the membrane. The latter condition is to be looked for with special care in the posterior segment; in inflammatory diseases any bulging of the posterior superior meatal wall adjacent to the membrane is very significant of suppuration in the antrum. In non-suppurative conditions any particular prominence of the posterior

fold of the membrane must be looked for; in elderly people the existence of a circular peripheral opacity resembling the arcus senilis will frequently be observed. When no perforation is present, and deafness is the prominent symptom, the mobility of the various parts of the membrane and of the handle of the malleus should be ascertained by the use of Siegel's speculum. Indeed, the importance of an intelligent use of the pneumatic, or Siegel's, speculum in all cases of non-suppurative disease of the middle ear cannot be overestimated. At this period of the examination it is well to proceed to investigate the nose, naso-pharynx, and pharynx, while the patient is still in a good position with regard to the light.

Examination of the Nose and Naso-Pharynx.

An examination of the ear is not thorough and complete unless accompanied by a systematic examination of the nose and naso-pharynx. The importance of this has long been recognised, especially in those aural diseases incident to childhood, which largely depend for their origin on conditions connected with the presence of adenoid vegetations in the naso-pharynx. Indeed, Toynbee first described these growths under the name 'thickened membrane causing obstruction of the faucial orifice of the Eustachian tube,' to which he was in the habit of applying nitrate of silver with a curved porte-caustique. Besides this abnormal state there are numerous morbid conditions in the nose and naso-pharynx which are responsible for secondary pathological processes in the ear; unfortunately, in a large majority of cases treatment directed to the removal or correction of abnormal conditions in the nose and naso-pharynx will not be attended with any marked improvement in the hearing power on account of the duration of the aural complaint, which has resulted in permanent injury of the ear itself. This failure is apart, however, from any comfort accruing

to the patient from careful attention to the nasal trouble; nevertheless, by local treatment of this kind it is possible to retard the progress of the disease in the ear. From a pathological standpoint it is thus possible to obtain valuable information which may assist in determining the origin of aural complaints.

The examination in question consists in the inspection of the nasal chambers from the front, a procedure known as anterior rhinoscopy; from behind, the naso-pharynx and posterior choanæ may be indirectly viewed, a method known as posterior rhinoscopy. In order to inspect the nose from the front, reflected light is directed by means of a forehead



FIG. 17.—THUDICHUM'S NASAL SPECULUM.

mirror into the anterior nares, the alæ of which are held apart by means of one of the various forms of nasal specula, Thudichum's being probably most convenient. At the commencement of the examination the head should be kept perfectly upright, the tip of the nose being elevated by the examiner. In this posture the lower part of the septum and the front portion of the inferior turbinate body can be examined. Theoretically, the septum should be perfectly straight antero-posteriorly, and the inferior turbinate body should be separated from it by an appreciable distance, on an average $\frac{1}{16}$ inch. The lower edge of the inferior turbinate should also be separated from the floor of the nose by an interval of about $\frac{1}{16}$ to $\frac{1}{8}$ inch for its whole length. The septal mucous membrane has a yellowish-pink hue, whilst that of the inferior turbinate is pink.

The abnormal conditions frequently found in the nose are irregularities in the direction of the septum, as deflections from the perpendicular plane and localized projections, the latter being commonly known as crests or spurs. The abnormal states of the turbinate are usually evidenced either by an increased or diminished size. The increase in size of an inferior turbinate is greatest when the septum is deflected towards the opposite cavity; in these cases the bone, as well as its mucous covering, will often be hypertrophied; the diminution in size is most marked in advanced cases of the disease known as atrophic rhinitis—in fact, the bone may be completely absorbed with the exception of the anterior extremity. The nasal cavity then appears very large and roomy, and is usually filled with offensive crusts, the removal of which not rarely enables the examiner to observe the orifice of the Eustachian tube and the superior edge of the posterior choana.

From the point of view of the aurist, the most important division of the nose is the inferior meatus and the part below the middle meatus, for it is in any interference with the current of air normally directed into the mouth of the Eustachian tube, as well as in certain pathological changes in the mucous membrane, for example, rhinitis sicca—more noticeable on the inferior turbinate body than elsewhere—that his interest lies.

Posterior rhinoscopy consists in the examination of the naso-pharynx by means of a mirror. The patient slightly throws back the head, the mouth is opened, and the tongue depressed by means of a tongue-depressor, the most generally serviceable pattern being the old-fashioned one, with a blade of large size, as it causes less irritation, and keeps down the entire tongue better than the smaller patterns. A small mirror—either one worked with a hinge, so that it can be elevated or depressed at pleasure (Michael's), or a small-sized laryngeal mirror, with the mirror bent at

a right angle to the shaft—is passed gently backwards over the base of the tongue, and it is possible to observe the reflection, part by part, of the whole of the naso-pharyngeal cavity. This procedure requires constant practice if valuable clinical data are to be obtained, and no opportunity should be neglected of acquiring and maintaining the necessary dexterity. It is necessary that the soft palate be relaxed in order that a good view of the parts above and behind

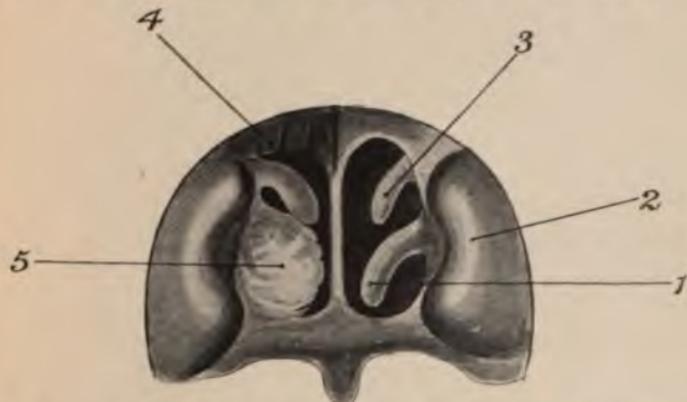


FIG. 18.—SEMI-DIAGRAMMATIC SKETCH OF POSTERIOR NARES, THE RIGHT (PATIENT'S) SIDE BEING NORMAL.

1, Inferior turbinate body, posterior extremity; 2, pharyngeal extremity of the Eustachian tube; 3, middle turbinate, posterior extremity; 4, adenoid mass, showing how the fornic of the posterior nares is hidden when this growth is present; 5, enlargement of the posterior extremity of the inferior turbinate body.

may be obtained; this relaxation is obtained by directing the patient to breathe through the nose without closing the mouth. Posterior rhinoscopy will be assisted by spraying the fauces in those patients with irritable throats with a small quantity of a 5 per cent. solution of cocaine; and a relaxed and passive condition of the palate may be occasionally assisted by placing the palm of the hand over the patient's open mouth, and directing him to respire through the nose. Before the presence of abnormal conditions can

be diagnosed, a knowledge of the normal anatomical appearance is necessary. The vault of the healthy pharynx is of a pale pink colour, and should extend considerably above the fornices of the choanæ. The orifices of the Eustachian tubes, with their projecting lips, should not extend sufficiently into the cavity to obstruct at all the view of the lower part of the choanæ. The posterior free edge of the septum formed by the vomer is straight and thin; and projecting into each choana from the outer sides are seen normally, as two pale pink unciform processes, the posterior extremities of the inferior and middle turbinate bodies, while in a relatively small proportion of cases may be observed in the upper part of the choanæ the free edges of the superior turbinate bodies. The more frequent abnormal conditions met with consist in an undue development of lymphoid tissues about the roof of the naso-pharynx. This overgrowth is known as adenoid vegetation (Fig. 18, 4); and in well-marked cases the roof of the chamber is lowered so much that the fornices and upper part of the nasal septum are invisible, and the roof, instead of appearing as a high vault, is convex and rugose, the whole of the space between the Eustachian tubes being occupied by the hypertrophic mass. In less severe examples it becomes most important to note whether the fossæ of Rosenmüller are free or occupied by lymphoid tissue, since in this way even a small amount of morbid growth will prevent free ingress of air into the Eustachian tube, by interfering with the movement of its free or posterior lip, and also by the extension of inflammatory catarrhal changes from the adenoid growth to the ostium.

There are numerous instrumental devices for holding the soft palate forwards in order to obtain a better view of the naso-pharynx in those patients who are unable to exercise sufficient self-control to keep the soft palate dependent and passive. By the aid of a little cocaine and the exercise of

patience, however, the use of such instruments and methods, which are extremely unpleasant to the patient, are in most cases avoided, and they ought not to be resorted to unless it is otherwise impossible to obtain the necessary information; nor should the practice of introducing the finger into the naso-pharynx to confirm the presence of adenoids be adopted as a routine measure. It is not usually necessary to do so even in quite young children, for the use of a post-nasal mirror is usually possible; and the introduction of a finger into the naso-pharynx frightens and, if roughly performed, hurts the child, rendering subsequent treatment less easy on account of the terror of the little patient. The following facts will in the great majority of cases determine the presence of adenoid vegetations in the naso-pharynx without any such investigation: A subject of adenoid vegetations snores at night, and is a mouth-breather, with dry lips, usually has a high palate, and there will always be granules present in the oro-pharynx. These signs, combined with either the presence of or the history of discharge from the ear or deafness, or the existence of an alteration in the direction and integrity of the cone of light on the tympanic membrane, are sufficient indications of naso-pharyngeal obstruction of this kind. (For the facial appearances in these cases, see *ante*, p. 24.)

An extremely important deviation from the normal is an enlargement of the posterior ends of the inferior turbinates (Fig. 18, 5), which become round masses, filling up sometimes the lower part of the choanæ, and projecting backwards for a considerable extent into the naso-pharynx. The appearance of these swellings varies much both in colour and size. They may look like mulberries, dark in colour, with a nodular surface; sometimes they are large masses, smooth and red; at other times white and glistening, resembling a nasal polypus. Similar changes to the last variety are noticed, but less frequently, in connection with

the middle turbinate. Other conditions, such as the presence of polypi, adherent crusts, or an atrophied state of the mucous membrane, though frequently observed, have, with the exception of the atrophy, little direct bearing on aural disease; but they should always be noted, with the view of treatment upon general principles.

As part of this examination, the size of the faecal tonsils and the colour of the mucous membrane of the posterior wall of the pharynx are to be observed, enlargement of the faecal tonsils being rarely unaccompanied by enlargement of the post-nasal lymphoid tissue. It is rare that ablation of the faecal tonsils will alone be of any assistance in correcting the aural trouble. The pharyngeal wall should be inspected for the presence of the scattered and enlarged collections of lymphoid tissue surrounding the mucous glands of the part, manifested by small elevations, pale and glistening when there is no active catarrhal state present, but otherwise bright red. This condition is known as 'granular pharyngitis.' Inflammation of this kind and in this situation, whether acute or chronic, is pathognomonic of a post-nasal catarrh, the irritating mucus flowing over the pharynx causing the lymphoid tissue which surrounds the pharyngeal mucous glands to become swollen.

CHAPTER III

SPECIAL SYMPTOMS AND THEIR IMPORT

Deafness.—The relative amount of deafness, from slight dulness of hearing to absolute deafness, requires careful consideration, with its onset, duration, and apparent causation.

Pain.—Pain is present in all acute inflammatory disorders, especially if tending towards or accompanied by suppuration, whether it be in the middle ear or external meatus. In acute eczema of the ear the pain is of a burning character, but not very acute. In furunculosis of the meatus it is severe, lancinating, stabbing, or throbbing in character, and usually prevents the sufferer from obtaining sleep for several nights. Pain is present in the most marked degree in acute inflammation of the middle ear. In infants it will be detected by the child crying whenever the ear is touched or washed, or by the frequent placing of the hand over the ear and rolling of the head about on the pillow. These signs may be accompanied, when the inflammation is secondary to a broncho-pneumonia, by retraction of the head. In adults, pain in acute otitis media suppurativa is often most excruciating, and, though worse, resembles in character a severe toothache. That which accompanies acute exacerbations of chronic suppuration in the middle ear is less severe and less localized, though when due to the presence of a focus of suppuration in the temporal bone or to an abscess between the skull and the dura mater it

may be very severe as well as quite localized. It is more common in character radiating over the side of the head and down the neck. Pain over the side of the head, and extending down the neck with tenderness of the skull on palpation, or pain in the neck should direct attention to the possibility of intracranial disease. Pain is by no means so usual symptom in acute non-suppurative mastoid disease. Here it is neither severe nor constant, and is more of an aching character. Referred pain in or about the ear from diseases in neighbouring regions is occasionally met with. Especially is this so in malignant disease of the pharynx and larynx and upper part of the oesophagus, in quinsy and dental caries of the upper jaw, and it is said to be due occasionally to nasal obstruction. Pain or tenderness on palpation over the mastoid will always lead to a suspicion of inflammatory disease in the mastoid; and above and behind the ear with discharge from the ear, to intracranial suppuration.

Discharge.—The character, consistency, quantity, and colour of the discharge should be carefully investigated. It may be offensive or odourless, purulent, watery, or sanguous, if purulent, it may be thin or ropy. Discharge is present in the following diseases:

Eczema of the External Meatus.—The discharge here is watery or gummy in character. It is rarely purulent, and when so, occurs in cases of long duration, when it will have a faint odour, due to the presence of decomposing epithelium.

Furunculosis of the Meatus.—Very severe pain has always preceded the discharge in these cases. It is thick, scanty, and purulent, and can be detected coming from a solitary spot in the meatal wall.

Otitis Media Suppurativa Acuta.—The discharge is occasionally watery or sanguous at the commencement, but gradually becomes purulent in a few hours, and may be ropy in consistency.

Otitis Media Suppurativa Chronica.—The discharge here may vary from an almost imperceptible moisture within the canal or a slight staining of the pillow-case at night to a profuse and continuous discharge. It may be most foetid, or, on the contrary, odourless; usually purulent, but at times almost watery. It is occasionally tinged with blood from the presence of polypi or granulations, or at other times the presence of small flakes of carious bone will have been noticed by the patient, in which case it is sometimes said to have an odour peculiar to diseased bone.

Otitis Media Hæmorrhagica.—This disease, which most frequently follows influenza, though not invariably, is characterized by the discharge of blood from the external meatus. This bleeding may be confined to a single discharge, or may be repeated.

Fracture of the Base of the Skull.—Should the fracture have passed through the temporal bone, blood will flow from the ear, and is sometimes followed by a more or less copious escape of watery discharge of low specific gravity—the cerebro-spinal fluid.

Malignant Disease of the Middle Ear or Meatus.—The discharge is scanty, very offensive, and sanguous.

Vertigo.—It is perhaps hardly necessary to remark that vertigo is by no means necessarily of aural origin, but that it may arise from numerous other morbid states of the system. Aural vertigo may be divided into two distinct classes—general vertigo and specific vertigo.

By a general vertigo is understood that variety in which there is no specific tendency for the patient to fall, or for objects to revolve, in any particular direction. It is a symptom in chronic non-suppurative disease of the middle ear, especially in that of the sclerotic type. The attacks are sudden in origin and vary much in severity, from a transient giddiness to an almost complete loss of consciousness, causing the patient to fall to the ground. It is also

present in all instances in which there is increased pressure within the labyrinth, such as occurs, for example, occasionally in gouty people and in the haemorrhagic effusions in leucocythaemia. It may also be caused by syringing at times when the drum is intact, and a forcible jet of water is sent directly against the tympanic membrane. When the membrane is perforated, the use of very cold or very hot lotions may cause vertigo. It is for this reason that a patient should always be seated while his ears are being syringed. With the ~~exercise~~ of every care, there are some individuals with sound ears who complain of giddiness whenever their ears are syringed.

Specific aural vertigo is due to irritation of one or other of the semicircular canals, in contradistinction to general vertigo, which is due to a general disturbance of the labyrinth, or to some force acting directly or indirectly on the fenestra ovalis. Specific vertigo has characteristics peculiar to the semicircular canal affected. If this is, as is most frequently the case, the external semicircular canal, objects have a tendency to rotate in a horizontal plane, while the patient falls towards the side which is affected. If it is the superior canal, objects rotate in a vertical plane, and the patient tends to fall forwards. This specific vertigo is occasionally noticed when syringing the ear in chronic suppurative disease or after the performance of the radical mastoid operation. In these cases it is due to erosion of the bony semicircular canal, while in inflammatory conditions of the temporal bone, caused by the same disease, this vertigo may be spontaneous, and is due to osteitis of the surrounding bone. In both cases it will be accompanied by a lateral nystagmus.

Severe general vertigo is a frequent symptom in abscess of the cerebellum. It may be caused in rare instances by a tumour pressing upon or involving the auditory nerve within the skull. Vertigo is also the chief symptom in Menière's

disease and in haemorrhage within the labyrinth in leucocythaemia.

Tinnitus, or Noises in the Ear.—Chronic tinnitus may be divided into noises referred to the head and noises referred to the ear.

Noises referred to the Head are either due to aural disease, or they may have a cerebral origin. In the former instance they have a hissing or singing character, are fairly constant and uniform in intensity, and often of long duration. When of cerebral origin, they occur as an early sign of mental derangement, and gradually take the character of voices ; and when tinnitus of aural origin commences to assume such a character, it is an indication for careful inquiry into the patient's mental condition.

Noises referred to the Ear.—These may be present in both suppurative and non-suppurative disease of the middle ear. They are more amenable to treatment than the former, and are not infrequently considerably mitigated by intranasal treatment. There are two chief varieties of subjective sounds—a pulsatory one, synchronous with the heart's beat, and due to an abnormal transmission of the sounds of the heart ; and tinnitus proper, due to a distinct intralabyrinthine cause. These latter sounds are described by the patients as being of a hissing, whistling character, at times likened to the noise of a boiling kettle, whilst occasionally loud musical notes are complained of. The singing sounds are the most constant, though the louder noises are perhaps the more annoying. The pulsatory sound is, as has been said, due to some abnormal condition either of the cardiovascular system or to some fault of bone conduction, which causes the sound of the heart's beat, usually inaudible, to be heard by the patient. That this is frequently due to some trouble in the vascular system may be deduced from the fact that drugs, such as digitalis, which act directly on the heart and bloodvessels, are very useful in controlling

the unpleasant symptom. The hissing or singing tinnitus is always more complained of at night or on rising in the morning—a fact which is partially due to the relative absence of extraneous sounds at these times, or it may be to the change of position.

Whilst tinnitus rarely prevents sleep, sufferers from this trouble frequently experience considerable difficulty in getting to sleep. In neurotic patients it may become so distressing and intolerable as to lead them to commit suicide. When tinnitus is complained of, and seems out of proportion to the aural disease, the urine should be examined for albumin—a clinical rule worthy of extension to all these cases.

Symptoms caused by Drugs.—Certain drugs cause both deafness and tinnitus, particularly quinine, the salicylates, and antipyrine. The deafness caused by these drugs usually passes away more rapidly than does the tinnitus. Although the administration of these drugs in patients with normal ears will cause no permanent ill-effects, it is well, in patients suffering from chronic non-suppurative diseases of the ear, to exercise great care and circumspection in prescribing these remedies, as, according to Friedreich, there is a possibility of causing an effusion into the labyrinth, an accident which would intensify the aural trouble.

Nausea and Vomiting.—These are symptoms which present themselves in an acute increase of intralabyrinthine pressure, such as occurs in effusion into the semicircular canal in Menière's group of symptoms. They are also occasional accompaniments of the vertigo which may occur during the progress of non-suppurative disease in the middle ear. Vomiting is present in all forms of aural suppurative disease in which septic absorption has occurred, and is a prominent symptom in intracranial complications. When the vomiting occurs with cerebral or cerebellar abscess its onset is sudden, and without any connection with the ingestion of food.

Rigors.—Rigors, however slight, are of great importance,

and are found in a great number of septic processes due to middle-ear suppuration. They are most severe, and accompanied by the highest temperatures in septic infection of the lateral sinus, and in such cases are usually successive; they are present, though in a less marked degree, in septic meningitis and in acute cerebral infection.

Nystagmus.—Nystagmus is met with as a symptom in mastoid disease, in affections of the semicircular canals, and in cerebellar abscess or meningitis.

INDICATIONS FOR INTRANASAL TREATMENT.

Some general principles must be laid down for the guidance of the practitioner in deciding whether or not special treatment should be directed to the nose and naso-pharynx in cases of deafness and aural disease generally. With regard to the presence of adenoid vegetations, their removal is practically invariably necessary for the cure of discharge from the middle ear in children, and should be promptly undertaken in every such case after the subsidence of all acute symptoms, both aural and nasal. The presence of adenoid vegetations cannot be looked upon as harmless when there is the slightest deafness detected, or when there is the least deviation from the normal in the curvature of the membrana tympani, as shown by the appearance and situation of the cone of light. Also, it must be allowed that the presence of these growths renders the occurrence of aural complications more likely in all cases of nasal catarrh; they are, further, a distinct complication in the exanthemata and in other febrile disorders. The question of the removal of adenoid vegetations in all cases where they are found is one on which there exists some diversity of opinion. Viewing the matter from the general point of view, we consider that, as soon as their presence is noted to any material extent, their removal for aural prophylaxis alone appears undoubtedly to be indicated.

There exists, however, a certain number of cases in which removal of the adenoid vegetations in non-suppurative disease of the middle ear will be unattended by any good results on account of the advanced stage of the aural disease, as even in children cases of sclerotic middle-ear diseases occur. When a catarrhal deafness has ceased to be amenable to treatment, no benefit as far as the hearing is concerned will follow the clearing away of these growths.

For the undertaking of operative procedures for the removal of intranasal deformities or for the relief of deafness, the indications are easily and clearly defined. Speaking generally, unless it is possible to improve the hearing by means of an inflation by the Eustachian catheter or by politzerization, the removal of hypertrophies of the mucous membrane or deformities of the septum is not likely to afford any aural amelioration. Intranasal surgery may be undertaken with advantage if it is possible to render more lasting any benefit obtained from special attention to the ear. This may be said to be so in most cases, especially those of catarrhal deafness, where relief has followed inflation of the ears. Here the removal of the enlarged posterior ends of the inferior turbinates is of all operations the most effective, both in improving hearing and in the relief of tinnitus, especially when the patient complains of a dull sensation in the region of the mastoid process.

In aural therapy, the removal of spurs, the correction of deviation of the septum, and the reduction of enlarged inferior turbinates to their proper size, have for their principal indication the necessity of a free and straight passage in the inferior meatus for the purpose of the introduction of the Eustachian catheter when even by modifications of the curve the surgeon is unable to pass it. The direct benefit to the ear in these cases is doubtful, and the operator should be very guarded and clear in his prognosis

as to the curative effects of any measures directed towards correcting such pathological or abnormal conditions.

The use of nasal irrigations in all cases of atrophic or hypertrophic rhinitis, when combined with non-suppurating middle-ear disease, should be a routine direction. A judicious use of the galvano-cautery is often beneficial, inasmuch as, though its results are not permanent, the improvement in hearing obtained after its employment proves the possibility of operative measures of greater extent being useful in the same way.

ESTIMATION OF THE ACUTENESS OF HEARING

There are the following means at disposal for estimating the relative acuteness of hearing: The human voice, the tuning-fork, the watch or acoumeter, Galton's whistle and other appliances, as König's rods. Of all these tests the human voice is the most important, but unfortunately often it is the least satisfactory in its results, since by a careless use it may demonstrate improvement where none exists, or, on the other hand, no increase in the hearing power is noted though other tests show its existence.

Testing with the Human Voice.—In testing with the human voice the examiner stands on one side of the patient, whose other ear should be closed, and care must be taken that the patient is prevented from observing the mouth of the examiner. Single words make the best test, those which are of special value and known to the patient being chosen. The first test is in repeating these single words in a clear, even tone, the voice of ordinary conversation. The patient should be made to repeat each word after the examiner with the eyes covered and the other ear closed, and the examiner should increase or diminish the distance between himself and the patient until he has arrived at the

limit of hearing for that tone. It may be necessary to increase the volume of sound by speaking more loudly in cases of considerable deafness, on the other hand, in every instance of slight disturbance of the function, it is advisable to sink the voice and to use a clear whisper. A whisper of almost uniform intensity may be obtained by emptying the lungs by a deep expiration and then whispering the word clearly but gently. The results are recorded as 'loud voice,' 'ordinary,' or 'whispered,' perceived at the respective distances; by repeating this test at intervals the examiner is able to obtain an approximate appreciation of the progress of any case.

In making these tests it is well to remember that certain vocal sounds travel better than others; the following is the order, taking the best travelling sounds first: Hissing sibilants and soft G's highly pitched; F sounds and explosives of medium pitch; deep tones. According to O. Wolff, letters, when used singly, should be taken in the following order: R (lingual), B, K, T, F, S, Sch, G (soft), U, D. In certain diseases some letters are heard worse than others. Thus, S and Sch are heard badly in diseases of the conducting apparatus, while F is so in labyrinthine disease, and R in defects of the membrane (Wolff).

Tuning-fork Tests.—No examination can be complete without subjecting the patient to a careful investigation into the state of the receptive apparatus and conducting mechanism by means of the tuning-fork. Tuning-forks of all sizes and pitches are to be obtained from the instrument-makers, but those which give the most practical results are 4C, to C⁴.

In order to obtain regular and definite results from tuning-fork tests, it is first requisite that a fork not only of a given pitch, but of a regulation form, size, and weight, be used for the chief or fundamental fork tests. A fork which fulfils these requirements is Lucae's C fork (128 double vibrations

per second), and, excepting for testing the upper and lower tone limits, and for differential diagnosis in certain difficult cases, answers all requirements (Fig. 19). The forks before referred to are used almost exclusively in ascertaining the integrity of the organ of Corti. The following tests will be found sufficient for general use, but for accurate diagnosis the special tests must be employed.

In using the tuning-fork the following directions should be carefully observed and followed: The fork (C) is struck gently on a hard substance protected by a soft covering, and the point of impact should be the prong, near to the shaft, and before being placed on the head or opposite to the patient's ear the fork should be tested by listening for the presence of overtones. The value of this caution lies in the fact that, if the test is made with a tuning-fork emitting overtones at one time and not another, the patient is practically being examined with tuning-forks of different pitches. This is unnecessary in Lucae's fork, as there is a mechanical device to prevent overtones. In testing with high-pitched forks the observer must not strike the fork too hard, as if the note is too loud it will be heard by the sound ear. Perception of sound may be diminished as well as destroyed, for which reason at times a moderately loud note is required to elicit the sense of hearing. The vibrating tuning-fork is applied to the patient's mastoid, and pressure must always be made with equal firmness, and, as far as possible, over the position of the mastoid antrum—that is to say, close behind the auricle, slightly above the orifice of the external meatus. The reason for using this particular spot is that the struc-



FIG. 19.—
LUCAE'S
TUNING-FORK
(c).

2, Vulcanite
foot-piece.

ture of the mastoid process itself varies considerably, from being so hollow as to consist of only a few large cells to the uniform density of compact bone. Having so placed the fork, the patient should be directed to hold up his hand the moment he ceases to hear it. The fork is then rapidly transferred to the observer's mastoid, and, if still heard, the difference is taken in seconds, the patient being credited with minus (-) seconds bone-conduction. If, on the other hand, when the fork is transferred to the observer's mastoid no sound is heard, the process should be reversed, and the patient is asked whether he recognises the sound after the observer has ceased to perceive it: should this be so he is credited with plus (+) bone conduction. It is in this instance unnecessary to estimate the number of seconds. The test is then repeated, the tuning-fork removed from the patient's mastoid the moment he ceases to hear it, and now held opposite to the external meatus on the same side; the practitioner must always be careful to hold the fork in the same way, since the vibrations are heard loudest and longest between the free ends of the prongs. If the patient still hears the fork the additional length of time is noted in seconds.

By means of these two observations it is possible to assume with considerable accuracy the state of the nerve-perception as shown by the length of time the sound is heard through the bone, and also of the conduction of sound as shown by the length of time the fork is heard in front of the ear. From these tests we may deduce: If the sound heard through the bone is a minus quantity and the air-conduction is fairly good, that the sound-perceptive power (internal ear or auditory nerve) is at fault, though pronounced otosclerosis is accompanied by diminution of the bone-conduction; if the air-conduction is shorter than the bone-conduction, whilst that is normal, the sound-conducting mechanism (drum, ossicles, or middle ear) possibly the nerves are at fault;

again, if the air-conduction is diminished, whilst the bone is normal or plus, the disease is in the middle ear alone. There are certain abnormalities of bone-conduction which must not be forgotten. The foremost amongst these is that the sound may sometimes be referred from one side to the other. At the same time, it is better to repeat the test twice or oftener, in order to obtain an accurate result. In advancing age—that is to say, from about fifty-four onwards—bone-conduction is greatly diminished without there being any actual nerve-disease present; as a sequel to certain diseases, more especially malaria, bone-conduction is lost, apparently much out of proportion to any concomitant disease of the auditory nerve or its endings.

Special Tests.

Weber's Test.—In Weber's test, the end of the shaft of a vibrating tuning-fork is placed on the vertex in the middle line of the skull in front of the ears, and is moved forwards until heard by the patient. It may be necessary, in this matter, to traverse with the fork the forehead, bridge of the nose, upper lip, and centre of the lower jaw. The patient is asked to determine on which side he hears the note the better. This test, which is only of real service in one-sided deafness, is based on the following experiment:

If, in a person of normal hearing, one ear is closed and the tuning-fork is used as described, the sound will be more distinctly heard in the obstructed ear; this fact is in all probability due to the reverberation of sound in the blocked passage. From this test we are able to make the following deductions: If the patient hears the sound better in the diseased ear, the trouble lies in the middle ear or proceeds from obstructions in the meatus. The conducting medium is faulty. If, however, he hears the sound better

A
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on the healthy side, the disease is most probably in the inner ear or auditory nerve, and the perceptive media are diseased.

Rinne's Test consists in estimating the length of time the patient hears the sound of the tuning-fork by bone- and air-conduction on either side as compared with the ratio of normal appreciation—viz., with C tuning-fork the air-conduction is longer by thirty-five seconds than the bone, and with C² tuning-fork the air-conduction is longer by fifteen seconds than the bone. The following is the method of interpreting the results: The test is 'positive' when, in a case of deafness, the fork is heard longer when held before the ear than when applied to the mastoid, and 'negative' when the sound is heard longer through the cranial bones. The positive thus indicates disease of the sound-perceiving, and the negative that of the sound-conducting, apparatus. This test is of no great value when the whispered voice is not heard more than 3 feet from the patient.

Gellé's Test.—Bone-conduction is diminished in the normal ear when the atmospheric pressure is raised in the external meatus by means of a Politzer bag or some such instrument. The value of the test lies in the fact that if the footplate of the stapes is fixed, no such diminution of bone-conduction takes place.

The Watch or Acoumeter.—The acoumeter is a small instrument invented by Politzer, in which a short metal bar (Fig. 20, C) is struck by a small hammer (Fig. 20, B), and as all acoumeters are made exactly to the same pattern, a uniform sound is arrived at, thus enabling observers in all parts of the world to express their results by one standard. This instrument should consequently be used whenever possible in preference to a watch. If, however, a watch is adopted, the observer should carefully test the limit of distance at which the tick of the watch is perceived

by a person with normal hearing, and any results he records should be in the form of a fraction, with the limit of distance in inches as the denominator.

In examining with either watch or acoumeter, the ear not being investigated must be closed. The instrument is then placed close to the ear, and moved steadily away until the sound is no longer perceived. Undoubtedly by

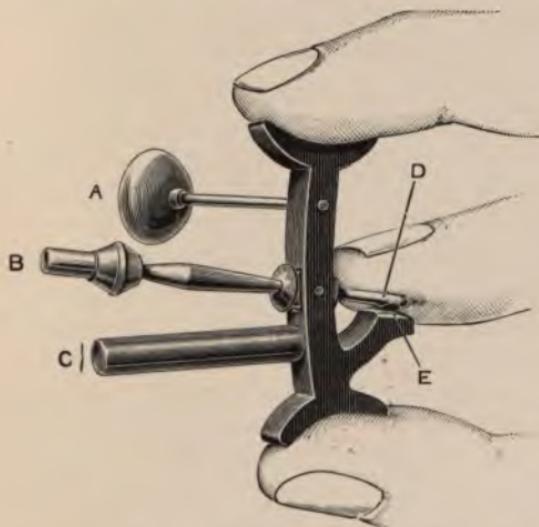


FIG. 20.—POLITZER'S ACOUmeter.

A, Disc for applying to mastoid; B, hammer; C, metal bar; D, lever; E, stop to ensure constant strength of stroke.

this means the patient is, as it were, able to follow the sound further than if the instrument is gradually approached to the ear, but whether the watch be removed from or approached to the ear, that method must be rigidly adhered to. In this test a silent room is more important than in using the voice. A source of fallacy in this test lies in the fact that if the watch or acoumeter be approached to within three feet of a wall the sound is intensified to the

listener, and the hearing distance thus made quite fictitious and misleading.

Both the human voice test and that of the acoumeter should be repeated after inflation of the middle ear, and any difference in the results noted.

Galton's Whistle gives the examiner the power of obtaining a rapid alteration in pitch, from the highest audible sound to one comparatively deep; a scale is attached to the whistle which enables the observer to keep a correct register of the limits of hearing in the higher notes.

GENERAL THERAPEUTICS—THE USE OF INSTRUMENTS

Politzerization.—This is a term now used to designate all forms of inflation of the middle ear by means of the contraction of an indiarubber bag, forcing a blast of air up the nose and into the ear through the Eustachian tube. This method was invented by Professor Politzer, and has the advantage of being easily performed by the patient himself or by the medical practitioner unskilled in the use of the catheter. It is, however, not so delicate a means of inflating the ear as by the bag and catheter, since it is more difficult to regulate the force of the air-current which rushes into the ear. For this reason it is wise only to make a limited use of politzerization, chiefly in the case of children or of very old people. Again, those who are constantly in the habit of passing Eustachian catheters can do so with almost no discomfort to the patient, and those who have not acquired the art of catheterization should lose no opportunity of improving their manipulation; their success in the treatment of aural diseases will be materially increased thereby.

To perform the act of politzerization an indiarubber bag of about 6 ounces' capacity is the chief requirement. The

ears of the patient and of the observer are connected by the auscultatory tube (see p. 57). The patient is then directed to take into his mouth a small quantity of water—about a dessertspoonful—and instructed to swallow it at a given signal. The operator next inserts the nozzle of the bag into one nostril, choosing the more patent side. With the finger and thumb of the left hand he now closes entirely the free nostril and any part of the other not occluded by the nozzle of the bag. He then gives the signal for the patient to swallow, sharply compressing the bag when the pomum Adami ascends, and observing, by means of the auscultatory tube, whether air has found its way into the tympanum or not. The patient's sensations are not entirely to be relied upon.

A modification of this method, introduced by Grüber, is the enunciation of the word 'hic' instead of swallowing the water, the bag being compressed at the moment the patient phonates. In children it is sufficient to cause them to keep the mouth open, and in adults merely blowing out the cheeks with the mouth closed is often as efficacious as the other methods, and less disagreeable.

The Eustachian Catheter.—One of the most important methods of diagnosis and of treatment is the proper use of the Eustachian catheter. The catheter may be either of metal or vulcanite, long or short, ball-pointed or plain. It is now customary to advise the use of a short catheter of from $4\frac{1}{2}$ to 5 inches in length. To inflate the ear by its help an air-bag is required, with a nozzle fitting well and easily into the end of the catheter, and in addition an auscultatory tube; it is better to be provided with a fine spray apparatus filled with a 5 per cent. solution of cocaine. The lower meatus is first anæsthetized with a very small amount of cocaine, 3 minims or 5 minims being sufficient for either side. One end of the auscultatory tube is now placed in the patient's ear and the other in the ear of the

observer ; it should be so made as to retain itself in position, and should neither be held in the observer's hand nor touch the patient's or surgeon's clothes. The tip of the patient's nose is now slightly elevated with the thumb of the observer's left hand, the fingers resting on the forehead. The catheter is held in the right hand with the beak pointing towards the patient, and introduced into the nose with the shaft almost vertical. The ring end is then elevated so that the shaft lies horizontally, and passed gently but firmly back, the point resting on the floor of the nose ; at the moment the tip of the catheter leaves the firm upper surface of the hard palate the catheter is rotated so that the little ring close to its mouth points more or less to the orifice of the external meatus on the same side. The catheter will now be engaged in the pharyngeal end of the Eustachian tube, and is maintained in its place by the finger and thumb of the left hand. The observer now notes carefully that the auscultatory tube is quite free, for if it touches any portion of the clothing adventitious sounds are created and erroneous impressions derived from the sounds heard. The nozzle of the indiarubber bag is then inserted into the end of the catheter, and air forced up by sharply compressing the bag. In the event of the catheter failing to engage the end of the Eustachian tube, the point may be rotated towards the opposite ear, and the catheter gently drawn forwards until it strikes against the posterior edge of the septum nasi, when a half revolution will immediately cause it to engage in the tube. This is not to be done unless the surgeon fails, after several attempts, to find the tube by the previous method. The other methods of passing the catheter are really inferior to the one just described, though they are, perhaps, in more general use.

Other Methods of Passing the Eustachian Catheter.—In all of these the catheter is passed directly backwards until it

touches the posterior wall of the pharynx. In the first, when this has been done, its beak is then turned outwards so that it enters the fossa of Rosenmüller, a depression just behind the posterior lip of the pharyngeal orifice of the Eustachian tube. It is then drawn forwards with its beak pressed outwards, when it will be felt to pass over this posterior lip, after which the catheter is immediately turned slightly upwards, and it should then have engaged itself in the orifice of the tube. This method is recommended by Politzer as being most satisfactory.

Another plan is: After having touched the posterior wall of the pharynx, the catheter is drawn forwards for $\frac{3}{4}$ inch, and then rotated outwards, when the beak should enter the orifice of the Eustachian tube. This can scarcely be a satisfactory method, as it presupposes the naso-pharynx to be of uniform depth in all people.

A very safe method consists in drawing the catheter forwards, after having touched the posterior wall, with its beak turned towards the opposite ear, until the forward movement of the catheter is checked by the posterior edge of the vomer. The catheter is then rotated outwards through half a circle with the point downwards. The catheter will then invariably be found, if properly turned, to have engaged itself in the orifice of the Eustachian tube. This procedure has one great disadvantage, in that it is extremely disagreeable, and often painful.

When it is impossible to pass the Eustachian catheter down one nostril, catheterization may be done from the opposite nostril by passing the catheter and rotating it towards the Eustachian tube. The instrument must be rotated at the moment it passes over the edge of the hard palate, but it may be, and often is, necessary to make the curve of the catheter at its beak almost that of a right angle with the shaft.

The difficulties which are met with in passing the Eus-

tachian catheter are due either to irregularities in the nasal passage or to irritability of the palate. To the experienced hand, the nose so narrow and irregular that the catheter cannot be passed with the aid of cocaine and delicate manipulation is very rare. If obstructions are met with in passing the catheter in the manner described, with the beak on the floor, it must be rotated either outwards or inwards, and pressed gently but firmly backwards, regaining, if possible, the correct position after clearing the obstruction. It is sometimes necessary to make a bend in the shaft of the catheter, with the convexity on the same side as the loop; it occasionally helps considerably to straighten out partially the curve at the tip. If difficulty is experienced in rotating the catheter, it is either due to the curve being too long or to the patient making tense the soft palate. If the curve is too great, the catheter must be withdrawn and the curve modified. Should, however, difficulty arise from irritability of the palate, it may be overcome by the help of cocaine, or by the exercise of self-control on the part of the patient. Sometimes the catheter does not pass easily into the mouth of the Eustachian tube. The act of swallowing on the part of the patient will usually overcome this difficulty. The only danger in passing the catheter is from the employment of unnecessary roughness, and the risk consists in forcing the tip of the catheter through the mucous membrane. Should this happen, and inflation be proceeded with, emphysema of the palate may be set up, and it was due to such an accident many years ago that catheterism fell into disrepute. Without undue force or carelessness injury of this kind can only happen during a softened condition of the mucous membrane consequent upon an acute catarrh of the naso-pharynx.

Too much care in disinfecting catheters cannot be observed, although, so far as the writer is aware, only one case has ever been reported, and that long ago in another

country, in which a serious disease was communicated by a dirty instrument.

The Auscultatory Tube.—This is a rubber tube fitted with an ear-piece at either end. These ear-pieces are usually of different colours, in order that the examiner may be able to keep one for his own use. The tube is used primarily to detect the entrance of air into the patient's ear during inflation, and secondarily to form an opinion as to the state of the ear and of the patency of the Eustachian tube.

It is of great importance to remember that the use of this tube is absolutely necessary in those cases of disease of the middle ear where inflation by the catheter or Politzer's bag is used for diagnosis or treatment; for, if the statements of the patient as to whether or not air enters the tympanum are solely relied upon, error is very likely to occur. The first cause of this error is that the patient suffering from advanced non-suppurative otitis media has usually lost, at any rate to a large extent, tactile sensibility in the mucous membrane of the middle ear. The second is that some patients will state that air has entered the ear on account of the unpleasantness of the process of inflation when it has not really done so. And, lastly, especially in hospital practice, the patient does not always understand thoroughly what is expected of him.

Information gained by the Auscultatory Tube in Inflation of the Middle Ear.—The sounds heard by means of this tube are of great use in diagnosis, but the finer appreciation of them is only obtained by practice and experience. The sound heard in any ear on inflation varies with the size of the Eustachian catheter employed and the force of the blast of air used. It is also influenced by the presence or absence of swelling or stricture in the lumen of the Eustachian tube, also by the nature of the contents of the middle ear and the mobility of the drum and ossicles. The following modifications of sounds may be easily recognised :

Fluid in the ear gives a fine crepitation ; stenosis of the Eustachian tube a distant and sharp sound ; an abnormally dry ear with a lax membrane an almost rustling sound. In obstruction of the Eustachian tube the stream of air which enters is necessarily small, hence the higher pitch of the sound. Again, a large catheter and a free tube causes a large sound ; while, on the other hand, a fine instrument will give a smaller one.

Syringing.—The aural syringe should have a capacity of 4 to 6 ounces, and at the present day may be obtained with the plunger, as well as the rest of the syringe, made of metal, consequently being capable of ready sterilization by boiling. It should have a nozzle coming to a fine tip, and be provided with two rings attached to the barrel of the syringe for the support of the fingers, as well as with one at the top of the piston-bar. Another improvement is the easy detachment of the nozzle, which enables the syringe to be filled more readily ; the bore of the nozzle must be of large size at its proximal end, and be gradually diminished as it approaches the tip, in order to reduce friction.

In syringing the ear for suppurative disease an antiseptic should invariably be used. If, however, the syringing is only for the removal of wax or a foreign body, water is all that is necessary. The water, or lotion, should be used as hot as the patient can bear it. In the case of a foreign body or a suppurative disease a comfortable temperature is sufficient. Hovell recommends the temperature of 96° for the removal of wax.

To syringe efficiently the ear the auricle is pulled away from the head and slightly upwards, in order, so far as possible, to straighten the meatus, the syringe having been previously filled and upended, so that any air present in the barrel shall rise towards the nozzle and be expelled by pushing the piston till the water flows steadily. The nozzle is now laid along the posterior meatal wall, and

gently but firmly pressed against it, and the contents of the barrel discharged into the meatus. The stream should always be fairly forcible, and, so far as possible, uninterrupted; if, perchance, air remains in the syringe, the moment it is heard entering the ear the syringe should be removed and recharged. The careless performance of this simple procedure has often resulted in unnecessary pain and injuries to the meatal wall and drum, accidents which are avoidable, and not to the credit of the surgeon. The patient should always be seated while the ear is being syringed for whatever purpose.

After the syringing has been completed, all moisture

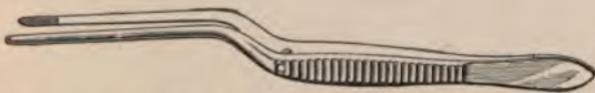


FIG. 21.—AURAL FORCEPS FOR CLEANSING THE EAR WITH COTTON-WOOL MOPS.

should be removed from the external meatus by means of pledges of cotton-wool.

When the ear is syringed for the removal of pus, it is an excellent method to attach a piece of fine indiarubber tubing to the nozzle of the syringe; by introducing the rubber tube deep within the canal the stream of water may be brought directly into contact with the recesses of the meatus and the middle ear both quickly and painlessly.

The Pneumatic or Siegel's Speculum.—This instrument consists of an aural speculum with the addition of a vulcanite cylinder, across the interior of which a piece of glass is fixed either horizontally or obliquely. The cylinder is attached to a piece of rubber tubing communicating with an arrangement whereby the air within the speculum is subjected to an increase or diminution of pressure at will. It is a good plan to connect this tube with a Delstanche's raréfacteur, this being easier to manipulate than a rubber

bag. The use of the oblique plane glass is strongly advocated as superior to the convex shape frequently supplied with this instrument. The instrument possesses three differently sized endings to fit variously sized meatuses, and it is often possible to obtain a closer apposition of the



FIG. 22.—SIEGEL'S PNEUMATIC SPECULUM ATTACHED TO DELSTANCHE'S MASSEUR.

a, The oblique glass-plate.

instrument to the walls of the meatus if over the end of the speculum a small piece of indiarubber tubing is drawn. Its use is to enable the surgeon to estimate the relative tensions of the various parts of the membrane, to detect adhesions of the membrane to the structures beneath, and to determine the amount of mobility possessed by the malleus. In

employing the instrument the largest speculum that can be made to enter the meatus is chosen.

After the air has been exhausted from the raréfacteur, or rubber bag, the speculum must be gently introduced into, but must tightly fill, the meatus. Having well illuminated the membrane, the raréfacteur, or bag, is allowed partly to refill, which it does at the expense of the air in the speculum and meatus. The eye will then detect any movement in the membrane itself, especially if the bag, or raréfacteur, is frequently and rapidly compressed and relaxed. The detection of immobility of the malleus is much more difficult, and requires a by no means small experience to eliminate error. In order to gauge the extent of the range of movement of the malleus, the speculum must be so adjusted that the tip of the malleus or its short process appears projecting slightly beyond its edge. Having carefully obtained one of these points, especially in the position named, rapid variation of the air-pressure within the meatus will, if the malleus is possessed of mobility, alter the relative position of the point to the edge of the speculum. By no other means is it possible to state with accuracy that the malleus is immovable, for the laxest part of the membrana tympani is the posterior superior quadrant; should the malleus be retracted, as it often is when morbidly fixed, the least suction outwards of this part of the membrane will give a false impression—the belief that the malleus has moved, when in reality nothing of the sort has occurred. This fact will be more easily understood when it is recalled that the membrana tympani is not intimately attached to the handle of the malleus in its upper half, and thus the thickened tympanic tissue lying external to the mallear handle takes part in all movements of the drum without of necessity communicating them to the malleus.

The Nasal Douche.—For this purpose either an ordinary nasal douche or straight glass syringe is sufficient.

The use of such a straight glass syringe has the advantage of being a less forcible method, and where the nose is at all obstructed there is less likelihood of causing the entrance of the fluid into the middle ear ; it is clearly superior to rubber syringes on account of cleanliness. Patients should always be directed to insert the syringe into the nostril which is the narrower or more obstructed, as the pressure will then be reduced in the naso-pharynx. The flow of the fluid is kept directly backward when the point of the syringe is maintained in a horizontal position ; if it points upwards, fluid is sent into the middle meatus, and not infrequently severe headache is produced. The fluid should be warmed to such a temperature as is most comfortable to the patient, and only sufficient force employed to insure a return flow by way of the other nostril. The nasal douche is in reality a siphon. The vessel containing the solution should be placed about 12 inches only above the head of the patient ; otherwise the force obtained may be too great, and incur the danger of entering the middle ear by way of the Eustachian tube.

Bougies.—It is at times necessary to use a bougie in order to dilate constrictions within the Eustachian tube. Such strictures lie within the cartilaginous portion, and as the catheter itself enters the tube for a short distance, it is quite sufficient for the bougie to be passed $\frac{3}{4}$ inch beyond the nozzle of the catheter. This distance is controlled by first marking on the bougie the length required for it to occupy the whole length of the catheter, and then adding a mark $\frac{3}{4}$ inch further on. Before employing the bougie the surgeon must first ascertain that the catheter is correctly placed by inflating the ear. The dilator is then passed, and retained *in situ* from two to five minutes, after which a gentle inflation may be employed, in order to ascertain the effect produced. But if the operator is under any apprehension that he has pricked the mucous membrane of the Eustachian tube, no subsequent inflation should be

employed for fear of causing emphysema of the tissues.

Lucae's Probe.—Lucae's probe is an instrument for the application of direct and intermittent pressure to the short process of the malleus, in order to increase its mobility in those cases where, from catarrhal adhesions, the handle of the malleus has become more or less fixed and limited in action. It has at its distal extremity a small steel cup coated with a solution of gutta-percha and allowed to dry. The probe itself is received into a hollow handle and works on a small spiral spring, which gives the necessary force required for restoring the lost mobility. Before proceeding to employ this method of treatment cocaine is applied to the drum, using either a 20 per cent. aqueous solution or Gray's aniline oil solution, the latter having greater power of penetration. Unless the drum is anæsthetized in this way the treatment is very painful. The head of the probe is applied under reflected light to the short process of the malleus, and pressure is maintained for a period not exceeding two minutes; this application is repeated daily for ten or fourteen days, according to the amount of benefit derived.

Air-Massage or Pneumo-Massage.

—The aurist has three separate means of employing pneumo-massage at his disposal—the finger, Delstanche's raréfacteur or masseur, and the manual or electro-motor pneumatic speculum.



FIG. 23.—LUCAE'S PROBE.

In employing the finger for massage the patient presses the tragus backwards so as to cover and shut the orifice of the external meatus, which little manœuvre is repeated rapidly for several minutes, using as much pressure as possible when closing the meatus in order to raise the intrameatal pressure.

The instruments of Delstanche are provided with a rubber tube terminating in a conical ear-piece, which is inserted into the external meatus, and then by alternately compressing and releasing the piston variations in pressure are produced. This method should not be employed for more than twenty seconds at a time to commence with. The period may be slowly increased with safety to as long as five minutes, and may be repeated several times daily.

When the electro-motor driven masseur is used the length of time must be carefully observed, commencing with half a minute daily, and increasing to a maximum of two minutes. With these instruments it is of great importance that the length of the piston-thrust be not over $\frac{1}{2}$ inch. Those usually sold are too long for ordinary use.

These methods are employed in the treatment of chronic non-suppurative diseases of the middle ear, both adhesive and sclerotic.

Brunton's Auriscope.—By means of this instrument an examination can be made without the aid of a head-mirror; the light admitted through a trumpet-shaped orifice is reflected into the speculum by means of a small mirror set at an angle within the instrument. The instrument possesses several disadvantages, the chief one being that it is difficult to manipulate aural instruments, even when a hole for the purpose is provided in the speculum; in the original model no such provision was made, it was therefore impossible to introduce even a probe into the ear while examining it. (A modified instrument is now obtainable which is less open to objection.)

Artificial Drums, Aids to Hearing, and Sound Deadeners.

Artificial drums are sometimes of assistance when there is perforation, or even complete destruction, of the tympanic membrane, in cases where the membrane is more or less adherent to the inner wall of the tympanum, and at times when the malleus is immovable. They are made either of rubber (discs) or of cotton-wool. The former are made with a wire stem, after Yearsley's model, or with a thread attached, after Grüüber's. The wool artificial drums may

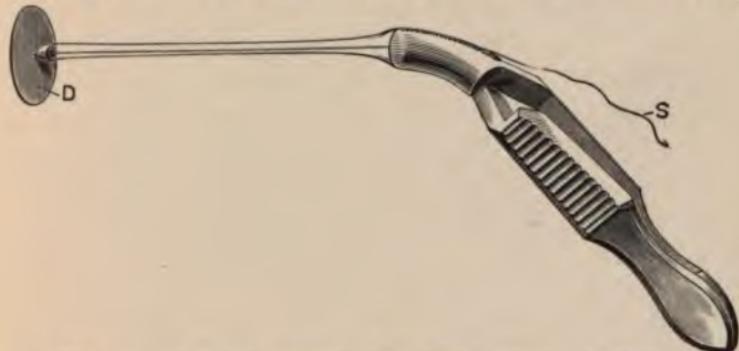


FIG. 24.—GRÜÜBER'S CARRIER FOR INTRODUCING ARTIFICIAL TYMPANIC MEMBRANES.

D, rubber disc ; *S*, thread attached to disc.

be compressed and cut into discs ; these when fixed on a wire are known as Toynbee's, and if to a thread as Field's, or the wool may be rolled tightly into the form of a round wick, with its ends cut off, so as to leave it about $\frac{3}{4}$ of an inch long.

Before using any form of artificial drum, all suppuration must have ceased for at least four weeks. The rubber disc must be trimmed with scissors to fit the ear, and is to be moistened with a little dilute glycerine and water rendered antiseptic with formaline $\frac{1}{5}$ per cent. ; the wool

drums often answer better if applied dry. The wool wick is introduced with forceps and Grüber's drum by special carrier (Fig. 24). The hearing must be tested before and after applying the drum, and slight alterations made in its direction until the best possible result is obtained; the foreign bodies are not to be employed for more than an hour daily for the first fortnight, in order to accustom the ear to their presence.

The various forms of ear-trumpet and of vulcanite are applied to the teeth and obtainable from instrument makers; they are of variable use, and the best plan is for the patient to go and try them, selecting some for a more extended trial at home.

Sporting men frequently require protection for the ear either from the wind in hunting or from the continual shot and noise of gun-firing in covert shooting. The same protection from noise is at times required when the auditory nerve is hypersensitive; for this purpose small vulcanite sound-deadeners may be employed, and Hawksley supplies an artificial cork which is even more useful.

CHAPTER IV

THE EXTERNAL EAR—MALFORMATIONS, INJURIES, AND DISEASES

Malformations

THE more usual malformations of the external ear consist either in an increase of size, or in deficiencies due to an arrest of development of the auricle; defects which vary on the one hand from quite small rudimentary nodules, situated in the position usually occupied by the pinna, and only containing a diminutive fragment of cartilage, to, on the other, any possible alteration from the normal in size and shape. Amongst the more common abnormalities may be noted the so-called supernumerary auricles, which may take the form of additional projections in the neighbourhood of the tragus, or may be situated in the neck at the site of the lower branchial clefts. These are of no importance, except from an æsthetic point of view (Fig. 25). When there is marked loss of development of the external ear, the external meatus is usually absent, or replaced by a small cul-de-sac, and there is no connection between it and the middle ear (Fig. 26). Another not infrequent deviation from the normal is the eversion of the concha (Fig. 27).

Plastic operations for the relief of deformity may be undertaken, but no precise directions can be laid down for guidance, as in those instances where operation is decided upon, each case must be dealt with as its own peculiarities

demand. It is generally useless to attempt to restore the external meatus, as there is in these cases bony occlusion of the canal beyond the end of the membranous cul-de-sac. Excellent artificial ears may now be obtained from instrument-makers, or from Brooks of Halifax.

The surgical treatment of protruding ears may be either confined in children to the use of straps, caps, and the like,

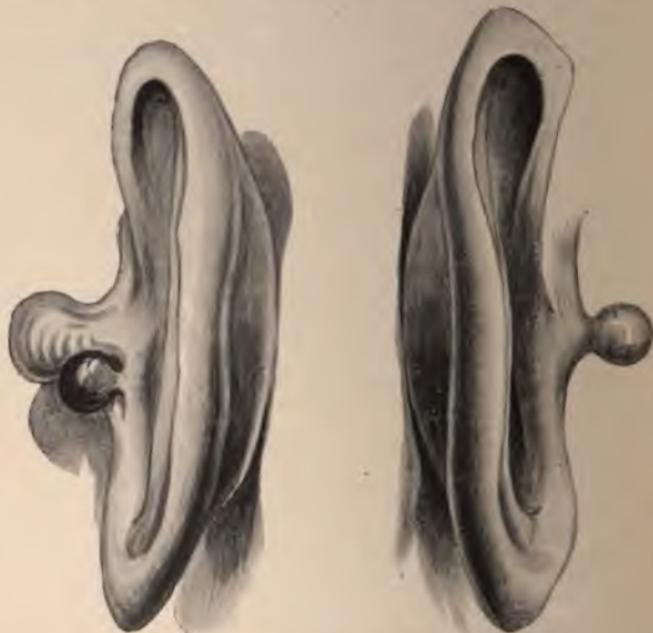


FIG. 25.—SUPERNUMERARY AURICLES.

which should be constantly worn, or operative measures may be undertaken. A wedge-shaped piece of skin and cartilage, wider in the middle than at the ends, is dissected out, and the wound sutured with silver wire or silkworm gut, drawing the cut surfaces of the cartilage and skin well into apposition. The ears are to be held back by a bandage for *at least four weeks afterwards*.

Injuries.

Frost-Bites.—The part affected, usually the tip of the ear, if seen early, is found to be dead white and absolutely insensitive. A marked degree of redness in the adjoining portion of the pinna is soon noticed, and in the course of a few days the area becomes black, and is ultimately thrown



FIG. 26.—MAL-DEVELOPMENT OF EXTERNAL EAR.

off. Superficial sloughing of the skin is very commonly found as the result of slight frost-bite amongst people exposed to severe weather—milkmen, drivers, etc.

TREATMENT.—In the first instance, the best treatment is to attempt the restoration of the circulation, which is best done by hand frictions with snow, the return of circulation being heralded by a severe burning pain. Should a

sphacelus have formed, a dry dressing of iodoform and cotton-wool should be employed, and no undue haste need be exhibited in removing the dead tissue so long as proper antiseptics are employed.

Chilblains. — This troublesome complaint frequently affects the ears, and requires the same local and general treatment as chilblains in any other part of the body.



FIG. 27.—MALFORMATION OF EXTERNAL EAR.

a, Eversion of concha.

Hæmatoma Auris. — The traumatic effusion of blood that takes place in the tissues of the external ear is situated in the majority of cases beneath the perichondrium, and the region involved is most frequently the upper posterior quadrant of the anterior surface; it is common in pugilists and football players, and is almost invariably due to direct violence. A similar condition is liable to be produced by very slight trauma, or to be aroused spontaneously, in patients suffering from insanity. — The skin covering the tumour

appears of a dusky purple hue, being rarely normal in colour. The temperature of the part is slightly increased and the tumour has a boggy feeling, unless the blood has been suffused into the subcutaneous areolar tissue, when fluctuation is more marked.

TREATMENT.—It is important to note that resolution is not certain to take place, but that if it does deformity is sure to result. For these reasons, and also on account of the safety afforded by the use of antiseptics, free incision of the tumour with evacuation of its contents should be undertaken immediately in all cases, the incision to extend from the top of the tumour to the bottom. All the blood-clot must be carefully removed, if necessary, with the aid of a blunt spoon, and the interior of the cavity cleansed with antiseptics and dried. The wound may then be sewn up in its entire length, and firm pressure applied by means of a bandage, so that the auricle is held firmly against the head.

Should, however, the patient refuse the rapid cure to be obtained by this method of treatment, the blood may be removed by means of an aspirator, and a dressing of collodion and gauze applied over the whole ear in order to obtain a fair amount of pressure, which may be supplemented by a bandage.

If the tumour be not of recent date, and there is already alteration in the cartilage, the serum, which will have separated from the clot, should be removed by means of an aspirator, and a cure attempted by pressure. If, however, reaccumulation occur, incision and scraping out of the cystic cavity affords the best prospects of success, or a little tincture of iodine may be injected.

Diseases of the External Ear.

The more usual diseases affecting the external ear are herpes, eczema, erysipelas, formation of cysts in the auricle,

and new growths. Of the latter, papillomata (Fig. 28), rodent ulcer, epitheliomata of the auricle, and fibromata of the lobule, are the commonest varieties.

Herpes of the ear possesses no feature to distinguish it from herpes in other parts of the body. Similar treatment must be adopted.



FIG. 28.—PAPILLOMA OF EXTERNAL MEATUS.

Acute eczema is best treated by the use of a powder of oxide of zinc and starch, made up in equal parts, or by any of the soothing ointments, such as oleate of zinc, 15 per cent., etc. Goulard water is a good application in the weeping forms. If, however, the disease is chronic, the skin of the part is much thickened, and from subacute exacerbations

of the inflammation the auricle often becomes a shapeless mass, giving rise to much discomfort both from the pain and irritation which accompanies it as well as from the discharge.

The same treatment must be carried out as for an acute condition, but as soon as the sharpness of the inflammation has subsided, the use of Hebra's diachylon ointment is a most valuable help. The ointment is to be well rubbed in with massage of the part several times daily, while at night the ear should be wrapped up in a piece of linen spread with the ointment. (Also *vide* Appendix 41.)

Eczemas here, as in any other part of the body, will often prove intractable to any one treatment. Strong solutions of nitrate of silver, 30 grains to the ounce, have been recommended as a treatment in the form of a paint when the external meatus is involved. Internal treatment in childhood consists in administration of tonics, in adults of anti-lithics.

New Growths of the External Ear.—With the exception of the fibrous tumours of the lobule, these tumours require no special description, as they possess no features peculiar to their situation.

The fibromata of the lobule are in reality keloids, and follow the wearing of earrings. When these enlargements become unsightly they should be removed, together with as much of the lobule as is necessary to obtain their complete excision, since if any part of the tumour remains they are extremely likely to recur.

The serous cysts of the auricle to which we have referred are found in much the same position as the othæmatomata—that is to say, the fossa triangularis. They are, however, spontaneous in origin, the temperature of the part is not raised, the superlying skin is normal in colour, and they are merely pink to transmitted light; whereas in the case of othæmatomata light is transmitted very badly.

The treatment of these little cysts is incision and free

scraping out, followed by antiseptic packing for a few days. If a cutting operation is for any reason undesirable, the fluid contents of the cyst may be withdrawn by aspiration, and a few minims of tincture of iodine injected into the cavity. The auricle should be protected by cotton-wool until the inflammation caused by the injection has subsided.

Acute Diffused Inflammation of the External Meatus presents itself either as an extension of similar disease involving the pinna, such as erysipelas or acute eczema, or it may be confined to the external meatus, as in acute eczema or acute gouty dermatitis ; on the other hand, it may have extended from the middle ear when that is acutely inflamed. If this diffused inflammation is merely an extension of an erysipelas of the surrounding parts, it presents no difficulty of diagnosis, and its treatment will vary in no way from that employed for the original disease, beyond the insertion, after all acute signs are abated, if required, of plugs of sterile gauze into the meatus in order to restore the calibre to its normal dimensions. In acute eczema of the external meatus, where it is confined to the meatus or has spread from the pinna, a watery exudation is formed which flows from the ear. This discharge will, if the external meatus is not regularly and thoroughly cleansed, soon become offensive, though rarely purulent, and is the condition often known by the name of *otitis externa*. The external meatus will be much reduced in size by the swelling of its walls, and an inspection of the deeper parts made difficult or impossible.

SYMPTOMS.—One of the chief symptoms is a watery, odourless discharge from the external meatus, though it is sometimes cloudy and offensive ; redness, swelling, and an inflammatory occlusion of the external meatus are frequent accompaniments, and may be present without any discharge. In recurring cases there is a tendency to permanent contraction of the canal. Vesicles and pustules are rarely

discernible in the meatus. In the deeper parts of the canal sodden epithelial cells collect. The patient complains of pain, deafness, much itching, and of a sensation of heat in the canal. In children this variety of eczema is frequently impetiginous, whilst in adults it is usually of gouty origin, and may be associated with eczema of other parts. In chronic eczema the discharge is usually less, though more often offensive. In these cases the canal is often permanently occluded through the formation of fibrous tissue in the deeper layers of its lining membrane. Irritation is more troublesome than pain, and in certain instances discharge is absent. The eczema is then of a dry scaly character, and there is no consequent contraction of the canal.

TREATMENT.—The constitutional treatment of this disease in children is the administration of iron and cod-liver oil, with the occasional exhibition of rhubarb and soda or hydrarg. c. creta at night; wholesome food and an open-air life materially assist in combating the trouble. In adults a careful attention to the dietary, with restriction of alcoholic beverages, more especially of beer and sweet wines, together with a prolonged course of citrate of lithia and the regular use of saline aperients, constitutes the most appropriate treatment.

Local Treatment.—In children suffering from an impetiginous eczema, the use of dilute ammoniated mercury ointment is indicated, which is to be applied to the whole of the affected surface once or twice daily by means of a pledget of cotton-wool wrapped round the end of a small probe; and as an alternative treatment boracic ointment will often be found serviceable. In adults, oxide of mercury ointment, 8 grains to the ounce of vaseline, is used in the same way in the less acute cases; and as an alternative treatment dilute ammoniated mercury or boracic ointment is useful, and in very acute cases zinc and starch powder. In all cases the canal must be syringed out from time to time

with weak warm boracic solution, 5 grains to the ounce, in order to remove shed epithelium, irritant secretion, and superfluous ointment. The tendency to contraction of the meatus in both acute and subacute cases may be checked by the insertion of indiarubber tubes as large as can be introduced into the external meatus. These must be frequently changed, as the greasy matter which forms the basis of all ointments will soon render them soft and useless. By stretching the canal, and by pressure, these tubes help to dissipate the inflammatory material present in the subcutaneous tissues, and at the same time they enable the surgeon more easily to apply his remedies and inspect the deeper parts.

In the treatment of acute inflammation which has extended from the middle ear, plugging the canal with a strip of sterile or iodoform gauze will be all that is necessary; and if, as occasionally happens in these cases, small bullæ containing clear or sanious fluid are found, they should be punctured before the gauze is introduced.

Otomycosis.—Certain fungi are not infrequently found in the deeper parts, especially of the external meatus, and particularly occur in the inhabitants of damp and insanitary dwellings. They are a common trouble to residents of sub-tropical regions. The more usual fungi are the *Aspergillus niger vel albus*, or one of the mucors.

COURSE AND SYMPTOMS.—The disease commences with an irritation in the external meatus, gradually becoming more intense and persistent, and, in occasional cases, a certain amount of eczematous discharge is present. The hearing may become affected, and pain is at times complained of. The disease tends to temporary remissions, but not to spontaneous cure. On examination of the ear, patches are noted in the deeper parts of the meatus, either of a dirty black or of a white or red colour, according to the particular fungus which is present. These discolora-

tions may be surrounded by patches of inflamed tissue. The final and differential diagnosis must be made by the aid of the microscope, a small portion of the growth, removed either by the forceps or by the curette, being subjected to examination.

TREATMENT.—The ear should be well syringed with warm boracic lotion, and any visible patches which cannot be so removed cleared away by means of a blunt scoop or the forceps. Alcoholic drops are to be instilled into the ear once or twice daily. The efficacy of a spirituous lotion for this purpose is increased if it contain one part per thousand of corrosive sublimate, or five parts per hundred of salicylic acid. The drops should not be continued for a longer period than four to six weeks without intermission, nor should they be persisted in if they cause irritation of the canal; in the latter case a mercurial ointment, applied in the way previously described, is to be used until all the symptoms of irritation have disappeared.

Circumscribed Inflammation of the External Meatus; Furunculosis or Abscess.—This kind of abscess, or boil, of the external meatus is of the nature of an infective inflammation involving one of the ceruminous glands and the surrounding tissue, and at its earlier stages it does not exceed in size that of a millet-seed.

CAUSATION.—An examination of the micro-organisms found in the external meatus of apparently healthy people commonly reveals the presence of the *Staphylococcus albus* or *aureus*, and it is to the entrance of one of these into the glands when the general health of the patient is somewhat impaired that the furunculosis is due, though it is probable that there is frequently in addition some previous slight inflammation of the canal. Occasionally this predisposition is caused by the presence of the aspergillus, by a discharge from the middle ear, or by the careless use of chromic acid or other powerful therapeutic agents.

COURSE AND SYMPTOMS.—The first symptom is that of irritation within the canal, followed by a shooting or throbbing pain, becoming of a very severe character, keeping the patient awake at night and causing an amount of constitutional disturbance entirely out of proportion to the local severity of the disease. The pain is increased by pressure on the meatus and by mastication, and glandular enlargement may be noted in front of the tragus or over the mastoid process. The pain is followed by discharge of a small amount of pus, thick in character, with partial relief of the suffering. As one abscess subsides another frequently appears, and this condition may persist for several weeks. The temperature is scarcely elevated in adults. Occasionally the abscess, even after rupture into the lumen of the canal, increases in size and penetrates the deep tissues, and, passing outwards beneath the cartilage, forms an abscess over the mastoid process, thence burrowing downwards in the direction of the sterno-mastoid muscle, and when thus presenting behind the pinna the abscess causes objective symptoms extremely similar to those caused by a subperiosteal collection of pus due to acute disease of the mastoid process. The furuncle is usually situated on the upper or posterior wall of the canal, more rarely on the anterior. If the abscess has penetrated the deeper tissues of the meatus the canal will be occluded, and pressure over the external swelling may cause pus at times to well out from the canal, though this observation is of no diagnostic value.

OBJECTIVE SYMPTOMS.—When furunculosis of the canal is suspected, a preliminary examination should be made without the use of a speculum, and if the disease is situated close to the external meatus, the pain occasioned by the introduction of a speculum may be avoided. If, however, the suppurating point is not visible, a speculum must be introduced, and with whatever care this may be done, a

certain amount of pain and discomfort is almost unavoidable. On inspection, it will be observed that in the canal and its external half there is either a distinctly tender spot situated at a slight depth from the surface, or there may be only an indefinitely marked diffused swelling. If the abscess has already ruptured, there will be a small point from which a minute quantity of pus exudes.

TREATMENT.—A free incision carried deeply through the centre of the abscess is the best treatment. This should be done if possible under the influence of a general anaesthetic, though the use of Gray's cocaine solution (Appendix 23) will to a large extent annul the pain, should chloroform or nitrous oxide gas not be available. Previous to incision, the canal should be thoroughly irrigated with either a strong antiseptic solution, such as 5 per cent. carbolic acid, or with peroxide of hydrogen 10 volumes. The contents of the abscess cavity are evacuated and the walls well scraped with a curette, and a plug of gauze soaked in 5 per cent. carbolic acid used as a light packing. This treatment tends to prevent recurrence of the affection. The dressings should be changed every twenty-four hours, the canal being first irrigated with peroxide of hydrogen, and afterwards with 5 per cent. carbolic acid solution. To control the pain it is frequently necessary to resort to the internal administration of morphia, while, according to some observers, the tendency to recurrence may be partly checked by the administration of calcium chloride. To ease the pain, if incision is not resorted to, hot antiseptic fomentations should be applied every four hours, or aural ovoids containing opium may be placed in the meatus, or chloroform vapour locally will give temporary relief.

Ulceration of the External Meatus.—Superficial ulceration of the external meatus is occasionally present as a secondary symptom in syphilis. The employment of *lotio nigra* will be found very efficacious in such cases.

Diphtheritic or Croupous Inflammation of the External Meatus.—The external meatus may be the seat of diphtheritic inflammation, and it can usually be traced to the entrance of foul water into the ear, as, for instance, after bathing in a dirty stream. The deeper parts of the meatus especially are covered with a false membrane of a white or yellowish-white hue, which, when detached from the skin, occasionally leaves a raw surface.

TREATMENT.—The canal should be frequently irrigated with a solution of perchloride of mercury, 1 in 2,000, and a 20 per cent. solution of lactic acid. Alcohol may be instilled into the ear in the intervals between the irrigations.

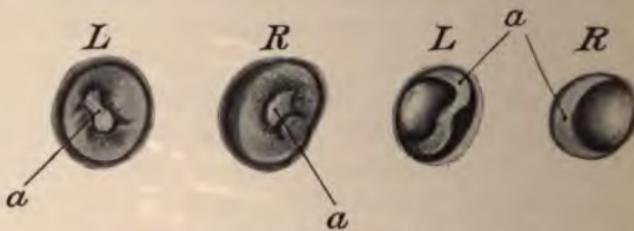


FIG. 29.—HYPEROSTOSSES AND EXOSTOSSES.

a, Lumen of the canal. The two left-hand figures are hyperostoses; the two right-hand ones examples of exostoses.

The external meatus is afterwards plugged with antiseptic gauze soaked in corrosive sublimate or lactic acid of the above strength.

Bony Growths.—Bony outgrowths in the external meatus are either diffuse or circumscribed.

THE DIFFUSED BONY OUTGROWTHS OF THE EXTERNAL MEATUS, or the so-called hyperostoses, consist of a more or less annular outgrowth of bone, which increases gradually and regularly, and contracts the meatus eventually down to an extremely small calibre (Fig. 29). They are caused either by an irritation set up by discharge or by some other form of irritation, such as a gouty eczema of long standing. The

outgrowth rarely, if ever, entirely occludes the canal. Its progress is slow, but it is not in itself a common cause of deafness; for where the hyperostosis almost occludes the canal, and there is no perforation of the tympanic membrane or discharge from the middle ear, there is usually concomitant pathological change in the deeper parts. When the hyperostosis is caused by irritating discharges from the middle ear, it becomes a matter of urgent necessity that the discharge be entirely and permanently checked, or that a radical operation be performed on the mastoid before complete occlusion of the canal occurs; for should the exudation be dammed up behind such an obstruction, absorption from pressure will take place, and serious sequelæ may be with confidence expected, either from septic absorption or from extension of the disease to the deeper parts of the temporal bone, and even to the intracranial structures.

Circumscribed Bony Growths or Exostoses.—These may be compact or cancellous, sessile or pedunculated. The spongy exostosis is of comparatively rapid growth, is single and sessile, and may be situated in any part of the meatus, from its external orifice to the margins of the membrane itself; it is covered by a layer of cartilage. The ivory exostosis is usually multiple, of slow growth, and occupies the bony meatus. The spongy growth tends to entire occlusion of the meatus, whilst the sessile ivory growths rarely completely obliterate the canal.

SYMPTOMS.—The symptoms are those of occlusion of the meatus—that is to say, deafness and noises in the ear. On examining the meatus, in the case of a sessile growth, the canal is found at this part either reduced to a crescent, smaller or larger according to the size of the growth, or it may be completely occluded by a round tumour of the same colour as the rest of the meatus. If, however, the growths are multiple, the canal is then more central, hourglass or roughly triangular in shape, and this small passage is rarely

entirely obliterated unless in consequence of inflammatory complication, or from the presence of impacted cerumen or epithelium.

The TREATMENT of these growths is based on the amount of obstruction they cause to hearing. Should there be no middle-ear deafness, and if, when the obstruction is complete, there is no reason to proceed to more radical measures, the growth may be removed with restoration of the hearing-power. As has been indicated, however, there is one marked exception to the foregoing rule, which is that operation should invariably *be undertaken without delay* in those cases where middle-ear suppuration complicates the condition, and the operation should then be that known as the radical mastoid operation, not merely an attempt made to restore the lumen of the canal. Should the occlusion by exostosis be complete, or almost so, especially if both ears are affected, one of the following operations may be undertaken. It ought to be borne in mind, however, that they are extremely difficult and delicate undertakings.

Operation for Spongy Pedunculated Growths. — Should the growth be within easy reach, one may attempt to remove it from the meatus by fracturing the base and twisting the growth off bodily by the aid of a pair of dentist's fang forceps; a strong wire snare is sometimes sufficient. If the surgeon prefer, he may cut through the pedicle by means of a fine chisel and remove the growth by avulsion. Another plan is to deflect the ear forwards by means of a semicircular incision behind the pinna, and having separated the meatus sufficiently to expose the growth, it is removed after cutting through its pedicle with a chisel. Should this method be adopted, the external meatus must be carefully plugged and kept plugged for at least ten days after the operation. When the growth is removed *via* the meatus the same treatment is to be adopted which will be described as suitable for the ivory or sessile growth.

Ivory or Sessile Growths.—The surgeon is here restricted to the use of the dental burr, or chisel, or compelled to deflect the pinna. In using the burr, the object is to remove the growth from the apex towards its base, attempting as far as possible to restore the calibre of the meatus to its original size. Burrs are to be preferred which have their extremities protected, but a small protector should be passed beyond the growth when the size of the canal permits, in order to protect the drum and middle ear from accidental injury. This kind of protection, however, is impossible in many cases, and the operator is to be guided entirely by his knowledge of the anatomy of the part. He must use his instrument, moreover, with the greatest care and dexterity. If the chisel is employed, there is no fitter instrument than the dentist's straight enamelled chisel; but since the temper of this instrument is very high, it should be held in the flame of a spirit-lamp until the blade turns to a blue colour when cold. When using the chisel, the growth is attacked near its base, and detached in as large portions as possible, though the manipulation in this, as well as in all other operations, is only learnt by experience. The dangers which are to be borne in mind are injury to the tympanic membrane and ossicles, or division of the facial nerve, by losing control of the instrument at the moment of overcoming the resistance afforded by the growth. After the growth has been removed to the satisfaction of the operator, the meatus must be thoroughly cleansed by irrigation with strong antiseptics, and an antiseptic plug inserted, and the case treated with the strictest antiseptic precautions until the healing of the surface is fairly complete. To avoid contraction or stenosis of the meatus it is advisable to insert a leaden tube as large as the lumen of the canal will permit, and it is not infrequently advantageous to commence the insertion of such a tube immediately after the removal of the growth.

Stenosis of the External Meatus.—Such a condition, when not congenital, is commonly the result of suppurative inflammation of the middle ear, and will be described as a complication of that disease. Marked contraction frequently follows chronic eczema, and may be situate at the external orifice or in the cartilaginous parts; in elderly people there is often noticed a falling in of the cartilage leading to a partial occlusion.

TREATMENT.—Congenital or acquired webs can be dissected away by means of a circular division of the tissue close to the meatal wall; a rubber or metal tube is then inserted, and should be of as large a size as possible. This is only removed at intervals for the purpose of cleansing the meatus for at least four to six weeks; nor should the case then be allowed to pass from observation, but should be seen from time to time for another two months, in order to check any tendency to recurrence that may show itself. Partial occlusion usually permits of dilatation by means of rubber tubes. Should the lumen be too small, dividing the tissues from the centre outwards will enable the surgeon to insert a tube. For collapse of the meatus or contraction at its orifice small dilators can be obtained at the instrument-makers, and are to be constantly worn.

Keratosis Obturans, or the Formation of Epithelial Plugs in the External Meatus.—This is a condition which occurs more frequently after middle age, and is due to an excessive casting off of epithelium within the deeper parts of the meatus and to its retention within it. If the disease has existed for a considerable time, the meatus is much distended in its innermost extremity, and the plug firmly adherent, or so tightly fixed that the line of demarcation between the dead and living epithelium is not clearly visible, and irritation is thus set up. This irritation increases the injurious effect of the pressure exercised by the plug, which is in its outer part formed of cerumen.

The symptom is chiefly that of deafness, accompanied occasionally by neuralgia of various parts of the head and considerable mental disturbance, especially in neurotic subjects, in whom a condition allied to melancholia sometimes develops.

TREATMENT.—First of all, an attempt is made to remove the mass by means of the syringe; but should this fail, as it frequently does, an endeavour may be made to separate the edge of the mass from the meatal wall by means of a probe, and then direct the stream of water from the syringe into the cleft thus formed, and so by means of *vis a tergo* expel the débris. Care must be exercised even by practitioners well skilled in the use of aural instruments in any attempt made to extract the mass by means of forceps or other instruments, more especially in elderly people, since pain and even rupture of the membrana tympani, which is at times attached to, and is always much weakened by the pressure of, the plug, may be caused. It is better to proceed more slowly, and to attempt to soften the mass by means of one of the guttae (Appendix 19) containing salicylic acid. These are instilled into the ear at night, and every second or third day it will be possible to remove with the syringe some portion until the whole meatus is clear.

As subsequent treatment frictions of the meatus with oxide of mercury ointment, as will be described under the treatment of ceruminous impaction, may be adopted; the meatus should be inspected every six months, especially if the canal is much dilated.

Diseases of the Ceruminous Glands.

Diminished Secretion.—When the secretion from the ceruminous glands is much diminished or entirely absent, the external meatus becomes very dry, and scales of cast-off epithelium are found within its lumen, which generally

appears wider than normal on account of a certain amount of atrophy having taken place in its lining membrane.

These patients complain generally of a large amount of irritation in the external meatus, and at the same time not infrequently of subjective noises within the ear, in which case the deficiency of secretion will be secondary to, and part of, a chronic disease of the middle ear.

TREATMENT.—The dry, scaly condition of the external meatus is best treated by gentle frictions with a little cotton-wool twisted round a wooden or vulcanite probe, and lubricated with dilute ammoniated mercury ointment.

Excess of Secretion.—Excessive secretion of cerumen is due to a diseased condition of the ceruminous glands, and is closely allied in character to a seborrhœa. The nature of the cerumen is altered and its quantity markedly increased. It contains less moisture, and tends to accumulate within the meatus. Both ears are usually affected, but one is, as a rule, more blocked than the other. When this accumulation of wax occurs in children, adenoid vegetations are usually present in the naso-pharynx ; when present in adults, it is generally accompanied by some form of nasal stenosis and chronic naso-pharyngitis. Such facts lead to the belief that the increased activity of the glands is either due to an extension of inflammation from the naso-pharynx via the Eustachian tube and middle ear to the external meatus, or to a reflex irritation caused by nasal or post-nasal irritation. The ceruminous secretion is mixed with dust, epithelium, and hairs ; it gradually loses moisture, and thus becomes darker in colour and firm or hard in character.

SYMPTOMS.—The constant symptoms of impacted cerumen are deafness, with or without subjective noises, and autophonia, whilst neuralgic pains over the side of the head may be induced ; irritation of a branch of the pneumogastric supplied to the skin of the meatus may cause a troublesome

cough. The deafness is usually sudden and complete, and can frequently be traced to the entrance of a small amount of water into the external meatus, thence between the ceruminous plug and the meatal wall; the deafness is due to the water stopping up this crevice, through which the sound-waves find their way, and later by causing the ceruminous plug to swell by imbibition, thus completely occluding the meatus.

TREATMENT.—The treatment consists primarily in removing the impacted cerumen, and secondarily in attempting to prevent its recurrence.

To remove the impaction recourse is had to the syringe, and it must be borne in mind that so long as the stream of water is directed along the posterior or superior walls of the canal, the amount of force used may and should be considerable. Under no circumstances whatever must the stream of water be directed against the plug itself, for this would only drive it further into the meatus, or, should it have been removed, the stream of water would thus strike fully on the membrane, and considerable damage may be done. A temperature of the water of about 96° is the best.

It frequently happens either that it is impossible to remove the plug at the first syringing or that its deeper portions cannot be evacuated. It then becomes necessary to adopt some means to soften the wax. One of the guttæ given in the Appendix (21, 22) may be prescribed, and a tea-spoonful of the warmed lotion instilled into the ear shortly before retiring to rest, the patient being directed to sleep lying on the opposite side, having lightly packed the affected ear with cotton-wool. These drops should be repeated on two or three successive evenings, when the mass will be softened, and is readily disintegrated and removed by the syringe. No instruments are to be employed in removing these plugs unless the surgeon has had much experience in their use, as it is very easy for unskilled hands to cause

irreparable damage by injuring the *membrana tympani* and the contents of the *typanum*.

After the removal of all the cerumen the *meatus* should be carefully dried, and, if possible, no further investigation of the patient for deafness carried out until the effects of the syringing have passed off, as all the tissues will be somewhat engorged with blood and the curvature of the membrane has often been affected by the pressure of the plug.

The treatment towards prevention of recurrence of the trouble is based on the assumption that this condition is due to a diseased condition of the glands, and so the remedies must be directed towards restoring them to a healthy condition. The following method will give very good results :

The patient must be supplied with a small wooden or vulcanite probe, and directed to wrap round one end of this a layer of cotton-wool, being careful that the wool projects well beyond the probe. He should then take on his forefinger a small amount of yellow oxide of mercury ointment, 8 grains to the ounce of vaseline, and gently smear this on the mop, taking care that there is no excess of ointment upon it. With a mop so prepared, gentle friction is applied to the external *meatus* over its outer $\frac{3}{4}$ inch once or twice weekly. Too much stress cannot be laid on the importance of parsimonious use of the preparation, otherwise patients may completely fill their ears with ointment.

New Growths.

Papillomata are occasionally found at the entrance of the canal, and should be removed with a scalpel, the base being cauterized.

Epitheliomata commencing in the external *meatus* are, fortunately, rare. When they do occur they are usually accompanied by great pain, not limited to the part involved, but radiating over a large portion of the head and neck.

There is a thin offensive sanguous discharge ; deafness is not a necessary result, unless the growth fungates and occludes the meatus. On examination there is seen a ragged ulcer, with piled up and thickened edges, which bleed readily when touched with a probe. The glands in the upper part of the neck are soon involved, and it could only be in very early cases that the surgeon would be justified in attempting to extirpate the growth. If it should be attempted, the operator must be prepared to carry out a deep, difficult dissection of the temporal bone. Sarcomata and adenosarcomata may arise in this situation, and since they both tend to recur, they are to be freely removed if seen early.

FOREIGN BODIES IN THE EXTERNAL MEATUS

These are usually met with in children, or, in the case of adults, they have been inserted into the ear in childhood and their presence forgotten ; they are then usually inanimate. Occasionally an adult will 'pick' his ears with a pin, which slips out of his fingers and drops into the deeper parts of the meatus. With these exceptions, foreign bodies in adults are usually of organized structure, such as polypi and necrosed bone, which are properly considered under the complications of suppurative otitis media. When a patient is brought with the statement that a foreign body is in the ear, it is a truism, but necessary, to say that, as far as possible, the practitioner should make certain that the foreign body is present before attempting its removal. He must remember that the extreme inner part of the floor of the meatus, as well as the lowest part of the drum, are frequently invisible, on account of the natural depression in the floor of the meatus at its inner part. Hence, if the sensation of the foreign body exists, no harm can be done in carefully syringing out the meatus.

Before proceeding, however, to the question of instrumental treatment, it is well to remember that even syringing for the removal of certain foreign bodies should not be attempted unless the surgeon is ready and able to take other measures. Vegetable seeds, if not removable by syringing, imbibe water and increase in size, often with disastrous consequences if operative measures are not quickly taken.

Foreign bodies in the external auditory meatus may be removed either by syringing or by the use of instruments, such as hooks and forceps. In a certain number of cases where neither of these methods avail, and where on account of swelling of the canal a severer complication threatens, it may be necessary to extract them by operative means.

Whichever method is adopted, the following precautions should be observed: (1) As the patients are usually children, with whom, unless exceptionally tractable, it is impossible to avoid damage to the important structures, the surgeon must have the help of a general anaesthetic. (2) It is essential that good light is available, and all manipulations are carried out with its aid. If the foreign body is one which presents a surface easily grasped by forceps or a hook, or if it is possible to pass a hook or fine bent probe beyond it, then nothing more requires to be done. If the substance is smooth, and the surgeon cannot pass an instrument beyond it, syringing will in most cases prove more efficacious. A small crevice usually exists between the foreign body and the meatus. This should be the side of the meatus along which the stream of water is driven, and particular care must be taken that, as far as possible, the object itself does not receive the force of the stream of water.

Other methods of removing the foreign body, as by means of suction may be considered. One of the most useful is by

means of a fine indiarubber tube drawn over the nozzle of a large rubber syringe or Politzer's bag ; it is then exhausted, and the moistened end of the tube pushed gently but firmly against the foreign body, whilst the bag is allowed to expand and sufficient suction is sometimes obtained to withdraw the offending object. A fine piece of thread may be sometimes attached by means of glue or a quickly drying cement to the foreign body, and it may be withdrawn when the adhesive material has had time to set. A fine wire loop may occasionally be passed beyond and around the object. It is often advisable, when the foreign body is one which will swell by the imbibition of water, to syringe with oil. But whichever operation is resolved upon, it should always be borne in mind that unless the object has been introduced into an ear already the seat of suppuration, it may remain for a long time without causing any disturbance.

If an insect find its way into the external meatus it can always be destroyed by chloroform vapour, and may then usually be syringed out. Filling the meatus with oil brings the intruder within reach of easy removal.

When from one cause or another the foreign body has set up such an inflammatory disturbance that the meatus is completely occluded, and it is impossible to remove it in one or other of the above ways, the ear should be reflected forwards by means of an incision close behind the auricle ; the cartilaginous meatus is gently separated from the bony posterior wall, and then divided longitudinally sufficiently far back to enable the surgeon to lever out the object by means of a fine instrument passed beyond it. If this step should prove necessary the post-aural incision is to be carefully closed, and the external meatus thoroughly washed out and plugged with gauze under strictly antiseptic precautions. If there is no discharge a plug may remain *in situ* from ten to fourteen days, in order to thoroughly re-establish the patency of the canal.

CHAPTER V

DISEASES OF THE MIDDLE EAR: ACUTE

Acute Inflammation of the Middle Ear—Otitis Media Acuta

THIS disease, rarely primary, is a secondary infection of the ear due to an inflammatory condition of the naso-pharynx. It is doubtful whether, even in influenza, the middle ear is ever affected without a previous infection of the naso-pharynx ; the only exception to this statement is in the case of primary deposit of tubercle in the middle ear. The middle-ear affection is usually directly due to a violent and rapid extension of the inflammatory process from the naso-pharyngeal mucous membrane to that of the Eustachian tube, and of the middle ear itself. Otitis media is a frequent complication of the various exanthemata and of acute infectious disorders. Foremost amongst these are scarlet fever, measles, whooping-cough, and typhoid fever. It also occurs secondarily to any naso-pharyngeal inflammation, more especially that accompanying the general symptoms of influenza, and it is at the same time one of the most serious complications of bronchitis and capillary bronchitis in children. Patients with obstructive nasal disease or those suffering from hypertrophic disease of the

PLATE I
ACUTE CONDITIONS

1. Left tympanic membrane in early stage of acute otitis media, showing enlargement of vessels, loss of lustre of membrane, and swelling and redness of handle.
- 2 and 3. Striae of the membrane, left and right, after attacks of acute otitis media, which have subsided without suppuration.
4. Acute otitis media: collection of pus in posterior superior quadrant, causing pouching of the drum; spot of pus exuding from perforation.
5. Acute tuberculous otitis media; bulging of whole posterior segment, which is dull and with enlarged vessels coursing over it.
- 6, 7, and 8. Hæmorrhagic otitis media of left tympani.
9. Acute serous otitis media in gouty subject, showing excessive vascularity.
10. Acute serous otitis media, showing dark line at upper edge of fluid, which is slightly too dark in colour.
11. Rupture of tympanic membrane (right); small perforation at tip of handle from direct violence.
12. Acute otitis, with formation of sanguous bulla in meatus, which is contracted by exostoses.

PLATE I.



1



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12



nasopharyngeal tonsil are especially liable to acute inflammation in the middle ear.

PATHOLOGY.—The inflammatory changes which have their starting-point in the nasopharynx cause engorgement of the lining membrane both of the Eustachian tube and of the *cavum tympani*; the whole of this swollen mucosa is infiltrated with leucocytes. The tympanic cavity then becomes more or less filled with muco-serous exudation, in which is found a variable number of micro-organisms mixed with leucocytes liberated from the lining membrane of the tympanum, the attic and the antrum. The *membrana tympani* itself is involved in the spread of the general inflammation, and a further extension of inflammation not infrequently proceeds along the external meatus, by which its soft tissues are swollen, with partial occlusion of its lumen; serous or sanguous bullæ are sometimes formed on the meatal walls, and are followed, after the absorption or removal of their contents, by desquamation. In fact, in this disease it is not an infrequent experience to obtain an almost complete epithelial cast of the external meatus.

SYMPTOMS.—Pain is the prominent symptom, and in character it may be paroxysmal or continuous. Patients refer it usually to the ear, but frequently it radiates over the affected side of the head. The pain is increased by pressure on the tragus, and often by movement of the jaw. It is worse at night, and accompanied by a relatively high temperature—from 101° to 103° F. A slight rigor is not infrequently experienced in the early stages of muco-purulent cases. A sense of fulness in the ear, autophonia, and deafness are as constant as pain. In children there may be delirium and convulsions; in very young patients it will often be noticed that the infant is continually putting the hand to the affected ear, or that he prefers to lie on the other side, and always screams when the ear is touched by the mother or nurse.

Incessant crying in children, not obviously abdominal in origin, should always direct the practitioner's attention to the sufferer's ears. As has already been mentioned, the membranous meatus is sometimes involved, and that even in the early stages of the disease. If so, its innermost part, if visible, is red and swollen, and bullæ, containing either clear or sanguous fluid, are occasionally noticed in this situation. The swelling of the meatus may be so great as to render impossible all inspection of the membrana tympani. It is in the membrana tympani itself, however, that the most characteristic changes are noticed. In the earliest stages of inflammation there is seen on the handle of the malleus a dilatation of its vessels, and on careful inspection a leash of vessels will be observed running from the posterior superior part of the periphery down to the handle of the malleus, near the short process (Plate I.). In the next stage the handle of the malleus becomes uniformly red, and small radiating vessels may be noted on the drum itself, the short process not altering in colour (Plate I.). As the inflammatory process develops the handle of the malleus loses its sharply-defined border, and resembles in shape the finger of a glove, and in colour changes to a bright red hue. It is at this stage that the epithelial covering of the short process becomes involved in the general inflammatory state, whilst the membrane as a whole gradually becomes pink, and the vessels radiating from the handle of the malleus more numerous and more dilated. The cone of light disappears, and the membrane becomes lustreless. From pink the membrane rapidly reddens, and the posterior half bulges outwards, hiding the anterior portion. At this stage it is impossible to distinguish the outline of the malleus or the edge of the tympanic membrane, for the adjacent parts of the meatus are also probably inflamed. Should the disease tend towards resolution, all the above-mentioned changes will take place in inverse order, with the exception

that, as the membrane recovers its normal colour and curvature, *striæ* radiating from the malleus will become visible in its posterior half. These are the result of the distension of the tympanic membrane, and are due to relaxation of its fibres when the distending force is removed ; they disappear in the course of a few days, and have no significance, whilst the membrane gradually becomes again lustrous, and the cone of light reappears. Should suppuration occur, the drum will be perforated, and the pus will show itself, if in sufficient quantity, in the external meatus. Discharge from the canal in these cases may be almost clear or sanguous at its commencement, but in either event it will gradually become purulent, and is very oftenropy in character. When the inflammation is severe and secondary to one of the exanthemata, the perforation may be of great extent and spread rapidly. The major part of the drum in such an event may be destroyed, and partial necrosis of the ossicles is a frequent complication. The whole membrane is sometimes destroyed in the course of a few days. If, however, the inflammatory products become localized and confined either to the attic or posterior superior quadrant, the practitioner will perceive on examination of the ear that, instead of the bright red uniform swelling as above described, there is a bright red pouch resembling a polypus hanging either over the malleus or behind it. In the former instance it is a bulging of Shrapnell's membrane (Plate I., Fig. 1); in the latter, a bulging of the posterior superior quadrant of the membrane (Plate I., Fig. 5). One may be able to detect a small granulation near the apex of the swelling. This spot is the site of the perforation of the pouch, and from its resemblance to a polypus a mistaken diagnosis may be made. When a perforation takes place in the anterior half of the membrane it is more difficult to detect than one situated in the posterior portions.

TREATMENT.—The objects which the practitioner must have in view in the treatment of the early stages of acute inflammation of the middle ear are, firstly, to relieve pain and to avoid suppuration and consequent perforation; secondly, in the event of perforation having occurred, to check the tendency to involvement of the mastoid antrum; and, finally, to check the discharge and heal the perforation. The treatment must necessarily vary with the general condition of the sufferer; also whether he is affected with a severe constitutional disease, such as scarlet fever, or if the local trouble itself is the chief or only complaint; and it may not be out of place to impress on the reader the necessity of a careful, methodical, and systematic examination of the ear in every case of acute specific fever, with the view of detecting inflammatory changes early, and by suitable measures aborting them. If the patient suffers from an acute infectious disease and the inflammatory condition of the ear is discovered quickly, three or four leeches should be applied over the mastoid, and hot boracic fomentations and aural irrigations employed, while the nasal cavities are sprayed with a mild antiseptic solution, either 25 per cent. of Listerine or a weak boracic solution. If, on the other hand, the inflamed state of the ear is the only disorder to be considered, a sharp mercurial purge is an advisable initiatory treatment, to be at once followed by a saline aperient. In adults 1 grain of opium may be advantageously added to the mercurial. At the same time three to six leeches are applied over the mastoid process, close to the attachment of the pinna, and further bleeding encouraged by hot fomentations of boric acid, the external meatus being syringed with the same solution. Instead of leeches, which are sometimes difficult to procure, artificial leeches may be employed. If the external meatus be obviously involved by the inflammatory process, one leech may be placed in front of the tragus; in

such cases the external meatus should previously be lightly plugged with cotton-wool. To relieve the pain, a piece of cotton-wool soaked in Battey's solution of opium or an aural ovoid (Appendix 26) containing opium may be inserted into the external meatus. Chloroform vapour is a very valuable local anodyne. If these measures do not rapidly relieve the pain, no time should be lost before proceeding to incision of the *membrana tympani* after a careful and thorough cleansing of the external meatus. It may be noted that the propriety of this procedure has been questioned in acute inflammatory disorders when a complication of the exanthemata. Incision may be practised for the relief of pain, even when no bulging of the membrane is observed. If any bulging of the *membrana tympani* is detected it becomes imperative. Incision in these cases must be free, and made vertically behind the handle of the malleus, extending from the top of the membrane to the bottom, a small incision being often worse than useless. This slight surgical measure is frequently advisable where a perforation is small and tends to become obstructed, thus preventing the free exit of the exudation. For this operation a sharp-pointed myringotome is required, and a general anæsthetic must be administered, and the meatus well illuminated. (For a description of the operation, see p. 176.)

After incision, as well as after pathological perforation of the *membrana tympani* has taken place, the ear must be carefully doused with some antiseptic solution, preferably that of perchloride of mercury (1 in 3,000). Peroxide of hydrogen is useful in these cases, as it decomposes the discharge and penetrates more readily and deeply than the mercurial preparation. After drying the meatus, some powdered iodoform is blown into the ear, and the meatus plugged loosely from the bottom with a thin strip of antiseptic gauze, care being taken to pack the deeper parts equally with the more superficial. This dressing is changed

as often as the external portion of the plug becomes moist with the discharge, the ear being irrigated in the same manner at each subsequent dressing.

An alternative form of treatment, or one which some aurists recommend in combination with the foregoing, consists in blowing into the middle ear through the Eustachian tube, by means of the catheter, a few drops of $\frac{1}{2}$ per cent. iodal oil in parolein, or the middle ear may be irrigated by the same means with sterilized normal saline solution. This may be done at the commencement of the treatment if the patient is able to tolerate it.

Acute Suppuration of the Tympanic Attic.

Inflammation may be limited entirely to the attic, and not involve the cavum tympani proper. In these cases the inflammatory process commences in the attic, and is sufficiently acute and accompanied by such an amount of infiltration and swelling of its lining membrane as to close the orifices left between the neck of the malleus, the long process of the incus, and the constricted walls at the base of the attic. The causes of acute suppuration in this region are catarrhal conditions of the naso-pharynx, extending up to and involving the middle ear and attic, but in which the drainage of the main cavity or cavum tympani is not interfered with by closure of the Eustachian tube. It is more common in adults than in children, and therefore is a relatively rare sequel of the exanthemata.

SYMPTOMS.—Deafness, a feeling of weight in the ear, and pain, followed by discharge. Deafness, in acute suppuration in the attic, is not so complete as that which occurs in inflammatory disease of the cavum tympani proper, even in the severest forms of attic inflammation, and in the milder attacks there will be only slight noticeable deafness; but in all cases there will be a sense of fulness and weight in the ear, together with more or less pain, and on

examination of the patient a small reddish tumour will be noticed situated in the upper part of the drum, and usually obscuring the short process of the malleus from a tendency which it has to become polypoid and dependent. This little tumour is smooth and of a bright pink colour, less intense than the colour of an aural polypus in this situation, and after discharge has commenced a granulation may frequently be noticed near the apex of the tumour, and by means of Siegel's speculum a small amount of pus may be caused to exude from the top. The temperature of the patient is rarely raised, nor does he suffer from any severe discomfort.

TREATMENT.—After thoroughly cleansing the canal, the bulging membrane is incised, or it may be cut off with a snare; the external meatus is subsequently irrigated and filled with aseptic packing. The gauze should be changed every day, and after the ear has been cleansed with an antiseptic solution, powdered iodoform or boric acid is inflated. The ear may be inflated after the attic membrane has been incised, in order to drive out any residual pus, a procedure which may be repeated before each dressing. By this treatment, if carefully carried out, healing may in favourable instances be obtained within a fortnight.

Complications.

Facial palsy; adenitis; mastoiditis; mastoid abscess; isolated abscess in the mastoid; perforation of the inner wall of the mastoid process, with subsequent abscess within the cranium; perforation into and purulent collection in the digastric fossa, with its possible extensions, as along the Eustachian tube into the pharynx; acute meningitis; pyæmia.

Facial Palsy.—Facial palsy is a symptom of no great significance in acute diseases of the middle ear, in which point it differs materially from chronic suppurative diseases of the middle ear. The paralysis is not of long duration if the aural disease is properly treated, and need not be looked upon as an indication for operation.

The nervous lesion is caused by an extension of the inflammation from the middle ear into the Fallopian canal, either on account of the thinness of its wall, or, as occurs in the majority of instances, in consequence of a small dehiscence in the osseous portion of the wall, usually situated just above the foramen ovale. When the inflammatory process has extended to the interior of the canal, both the periosteal lining of the canal and the neurilemma become infiltrated, and the nerve is thus compressed, with consequent paresis of the muscles supplied.

That variety of facial paralysis which sometimes occurs after exposure to a draught is due to a transient otitis media in which suppuration has not followed. The treatment of this complication, so far as the facial muscles are concerned, should be postponed until the inflammatory exudation within the Fallopian canal has subsided, when, if there is still any want of action on the part of the facial muscles, the faradic current is to be employed. If the paralysis, however, is of long standing from neglect of treatment, and the muscles exhibit the reaction of degeneration, voltaic interruptions of the constant current will be found more beneficial.

Adenitis.—The lymphatic glands, sometimes involved secondarily to an acute suppuration in the middle ear, are the pre- and post-auricular glands and those situated beneath and on each side of the sterno-mastoid muscle in its upper third. Should an inflammatory swelling of any of these glands take place, a by no means uncommon event in young people, resolution will be obtained by the application of heat, and of a mixture of equal parts of extract of belladonna and glycerine painted locally ; the absorbent action of this preparation is assisted in children and young adults by the administration of occasional small doses of hydrarg. c. creta.

Mastoiditis ; Mastoid Abscess ; Isolated Abscess in the Mastoid.—The earliest symptom of involvement of the mastoid is usually either that of pain on slight pressure at

the upper and anterior part of the mastoid process just behind the ear, or of tenderness on deep pressure at some other part of the bone, usually its anterior and lower limits. With such a symptom it is probable that suppuration threatens—in the former situation in the mastoid antrum, in the latter in some other part of the bone. A more or less superficial tenderness over the whole mastoid is rather an indication of a general periostitis. If suppuration takes place pain will then become pronounced on deep pressure, but the opposite side must be invariably tested to control the result obtained. Neuralgic pain is often felt on that side of the head. Fever usually returns if it had subsided, or a definite increase in the existing pyrexia takes place. The temperature often rises rapidly, to 103° or 105° F., and is accompanied, especially in children, by a slight rigor; in adults the temperature is at times not raised above the normal, or it may even be occasionally slightly subnormal, and no pain complained of except on direct and firm pressure. The discharge from the meatus often ceases entirely when suppuration occurs in the deeper parts, to reappear twelve to twenty-four hours later; at other times no alteration in the quantity will be noticed. Redness and swelling over the mastoid are present in the majority of instances, though they are observed less frequently as the patient's age advances. The softer and more porous the bone, the greater the rapidity with which this redness and swelling appear; if treatment be delayed pus collects beneath the periosteum, the ear projects from the side of the head, and fluctuation may readily be detected; the abscess will, if untreated, extend over the whole of the mastoid and upwards towards the temporal fossa. As additional evidence one may find bulging of the superior meatal wall, and slight nystagmus.

TREATMENT.—Whether or not the membrana tympani has been perforated, in the case of children, the application

of three leeches over the mastoid, followed by hot boracic fomentations to continue the bleeding, will again and again cut short the progress of acute otitis media, though, if these have already been employed just previously to the mastoid involvement, their re-employment is not advisable. Some observers recommend the antiphlogistic properties of cold, applied by means of a coil of rubber tubing through which cold water is allowed to flow. In the majority of instances, however, it will be found that leeches and hot fomentations are a more certainly abortive mode of treatment. Hot boracic irrigation of the meatus is always beneficial, and often alleviates the patient's sufferings. If at the end of twenty-four hours there is no good evidence that the disease is being controlled, the practitioner cannot too strongly urge the necessity of immediate operation, and he must point out the danger there is in unnecessarily delaying the opening of the mastoid antrum.

If, however, the case has been allowed to go on untreated, or if, despite treatment, an abscess is present on the mastoid, it will in children be usually found that the pus has perforated the outer layer of the bone. In these cases the patient is unable to sleep at night on account of the severe pain; the temperature is increased, and there are marked signs of constitutional disturbance. If the abscess external to the bone is not opened it will follow the course of any other acute abscess. Sloughing, with consequent perforation of the skin, will take place, with a free discharge of pus, and a sinus will be left leading down to the temporal bone and communicating with the mastoid antrum. In other cases the antral abscess will discharge itself into the external meatus by a perforation of its superior or posterior wall. In other instances, and usually in adults, where the outer table is of considerable density, and where the mastoid process is formed entirely of cells, the pus may perforate the outer wall of the digastric fossa, and then, following the direction

of the fascial planes, present itself in the pharynx, naso-pharynx, occipital region, or beneath the sterno-mastoid muscle—this variety is known by the name of 'Bezold's mastoiditis'—and occasionally at the same time pus may find its way into the sigmoid groove, and an acute extradural abscess be formed.

Intracranial lesions will be discussed subsequently (*vide p. 163 et seq.*).

Acute Tuberculous Disease of the Middle Ear.

It is not to be wondered at that the middle ear, with its irregular cavities, minute vessels and free lymphatic supply, should occasionally be the site of acute tuberculous inflammation. This variety of middle-ear disease is itself a comparatively rare complication, and but rarely found in patients already the subjects of pulmonary tuberculosis; it would therefore appear to be frequently a primary tuberculous lesion, the bacillus finding a lodgment in consequence of some local loss of the power to combat infection, either in the middle ear itself or in some part of the mastoid process. When the disease is secondary to a pulmonary lesion, it usually occurs late in the disease, and as such will rarely be seen by the aurist, and it then has a very serious significance.

SYMPOTMS.—The *Subjective Symptoms* consist of deafness, tinnitus, a sense of fulness in the ear, and discharge. The deafness is often sudden in onset, and found without any acute inflammatory state of the naso-pharyngeal mucous membrane. Pain is strangely absent in the majority of instances. When present, it is usually slight and transient in character, and may certainly be said never to approach in severity that usually experienced in simple inflammatory cases. The tinnitus presents no special features. The discharge is usually watery and scanty.

Objective Symptoms.—On examining the ear with the speculum, after cleansing the meatus, it may be possible to

detect a perforation, usually situated in the anterior part of the drum, whilst the posterior segment is bulging, and presents either a dull, pale pink colour, with enlarged vessels ramifying across it, or a uniformly dull-red hue. The membrane never presents that brilliant red colour seen in non-tuberculous inflammation of the mucous membrane. The swollen drum also exhibits a peculiarly sodden and thickened appearance, and if pressure is made upon it with a probe there is only slight yielding, and but little pain produced. Frequently there is slight fever, but the peculiarities of the inflammation consist in the relative painlessness of the perforation and the pathognomonic appearance of the drum. Enlargement of the post-auricular lymphatic glands is occasionally found. If the mastoid cells or antrum form the site of the primary infection, a rapid and painless mastoiditis ensues, with the formation of subperiosteal abscess, characterized by the absence of the common acute symptoms, especially of pain. Tubercles are said to be visible in the tympanic membrane in certain cases as gray, pearly spots. The process will, in such instances, be more acute, and a more rapid destruction of the tympanic membrane will take place, with a correspondingly rapid involvement of the surrounding soft tissues and bone: it will then be accompanied by severe constitutional disturbance.

TREATMENT.—In primary tuberculous disease of the middle ear the drum should be incised under a general anæsthetic through the whole vertical length of the most bulging portion; after incision, the posterior segment of the cavity of the middle ear is to be carefully curetted with a small sharp scoop. It is well to preserve for microscopic examination all the tissues removed, since the pressure of tubercle bacilli may be demonstrated in the débris, or the diagnosis may be verified by the inoculation of some of the material into a small rodent. The surgeon will notice that

there is no immediate tendency to collapse of the membrane, a fact which demonstrates that the drum and the membrane lining the middle ear are very much swollen, and that the bulging of the drum is due more to cell-infiltration and cell-proliferation, with the formation of tubercles, than to the presence of fluid in the *cavum tympani*.

After curettage the cavity of the middle ear must be well flushed with a 40 per cent. solution of lactic acid through a Hartmann's cannula. This irrigation is repeated at least once daily by the surgeon, and the wound in the drum kept open by breaking down by means of a probe any adhesions which may form between its edges; the meatus is to be firmly plugged with a strip of gauze soaked in a 20 per cent. solution of lactic acid.

It is needless to say that this local treatment must be supplemented by a proper constitutional regimen, and it is always advisable to examine the *naso-pharynx* with a view of discovering whether or not there is any discharge of pus from the Eustachian tube, as the pharyngeal vault or the larynx may in this way become infected.

Should the disease not yield to the above line of treatment, or the symptoms be fulminating in character, or the infection be primarily of the antrum or mastoid cells, then a most careful and thorough radical mastoid operation ought to be performed without unnecessary delay, and every vestige of the mucous membrane of the middle ear and of its subsidiary cavities, together with every trace of diseased bone, removed. (The general description of the radical operation will be found on p. 193.) Once the diagnosis is made, it is obligatory that the patient or his friends be made thoroughly acquainted with the serious nature of the disease, and that, trivial though it may appear to him, it is capable of infecting his whole system, and that, through the least negligence on his part, it may produce the most serious consequences. He must be enjoined to cleanse daily his *naso-pharynx* by

means of nasal irrigation. For this purpose there is nothing better than a 25 per cent. solution of Listerine.

As sequelæ, ulceration in the **naso-pharynx** is found, though comparatively rarely ; the muco-pus dropping down frequently infects the larynx, and also, by passing into the alimentary canal, causes general infection. If the operative treatment be not prompt and effective, the mastoid cells become infected from the middle-ear, and a large and ragged cavity forms in the temporal bone, destroying it entirely and infecting the system generally.

Acute Hæmorrhagic Otitis.

This variety of otitis media is, in the majority of instances, an accompaniment of or a sequel to **influenza**, though it does occur without known cause, and is occasionally a complication of renal disease ; it may also accompany a mild attack of otitis in patients afflicted with the hæmorrhagic diathesis.

SYMPTOMS.—The symptoms are pain and discharge of blood from the external meatus.

Objective Symptoms.—The membrane is not usually bulging, nor is the handle of the malleus reddened and broadened, but the membrane itself shows in the early stages a dull-red reflex, without material interference with the cone of light. This dull-red reflex is due to an engorgement of the mucous membrane covering the inner wall of the tympanum, and resembles in hue the dusky redness of the **pharyngitis** of influenza. When hæmorrhage has taken place, the drum exhibits, in most instances, in influenzal cases about the fifth day, at the lower and posterior parts, one or more small hæmorrhages ; sometimes even a small adherent clot of blood may be seen in the same situation (Plate I., Figs. 7 and 8). The duration of the complaint is about a fortnight, though, if due to abnormal conditions of the blood or general systemic disease, relapses may occur.

TREATMENT.—If the case be seen before haemorrhage has occurred, and the condition recognised, constitutional treatment may abort an attack. After a haemorrhage has occurred the ear should be lightly plugged with a strip of antiseptic gauze; if there is much pain, either the gauze may be moistened with a few minims of Battey's solution of opium or an aura lovoid containing opium inserted. It is not advisable to perform paracentesis of the drum for the relief of pain in these cases, as the haemorrhage which ensues may cause considerable annoyance.

Serous Catarrh of the Middle Ear.

CAUSATION.—Serous catarrh of the middle ear is invariably secondary to an inflamed condition of the nasopharyngeal mucosa, however slight or transitory this may have been. Careful cross-examination of the patient will always elicit the fact that, shortly before the aural trouble was noticed, there had been symptoms of nasal or nasopharyngeal trouble. The inflammatory process travels up the Eustachian tube by continuity of tissue, causing obstruction of its lumen, which results in an excessive mucoid secretion in the middle ear. The outlet being occluded, the fluid rapidly accumulates, and after subsidence of the swelling of the mucous membrane of the tube, the secretion remains in that portion of the *cavum tympani* which is situated at a lower level than the tympanic orifice of the Eustachian tube. It is rare in adults to find both ears affected at the same time, but subsequent attacks are common.

SYMPTOMS.—The chief subjective symptoms are a more or less pronounced degree of deafness, a sense of fulness in the ear, tinnitus, and occasionally patients express themselves as feeling as if 'something rattled in their heads' when they moved about. Not uncommonly there is a kind of double hearing complained of, the tone and pitch of a

note being altered on the side affected, while autophonia* a very constant symptom.

Objective Signs.—The membrana tympani is not visibly altered in curvature, but the cone of light is higher—that to say, slightly more horizontal—not often divided, showing that there is an alteration in the general curvature of the drum, though not sufficient to be appreciated by the eye. The most valuable sign, however, is the presence of a dark curved line across the drum, with its concavity upwards and its higher extremity posterior, simulating the appearance of a hair lying across the tympanic membrane. This line of demarcation indicates the upper limit of the fluid. The cause of this line being at a lower level in front is due to its extending to the lower margin of the tympanic orifice of the Eustachian tube, the higher level behind being due to capillary attraction. The line is caused by absorption and refraction of the light rays as they pass through the upper surface of the fluid. The part of the membrane below the dark line may appear quite normal, signifying that the fluid is composed wholly of clear serum; or this crescentic portion may be straw-coloured, due to the darker colour of the fluid; or, lastly, it may have a yellowish-white tint, caused by the mixture of a relatively large amount of mucus. Occasionally the whole membrane is divided into dark circlets with white centres. These are small bubbles of air and fluid. A similar appearance may be obtained after inflation if the tympanic cavity contains much fluid, as it is then made frothy. The whole or a portion of the membrane may be distended, with or without slight inflammatory blush in the region of the handle of the malleus in children. In these cases there will be no line of demarcation present.

TREATMENT.—The principles which should be followed in the treatment of this disease are, firstly, to obtain a free

* Hearing one's own voice loudly in the affected ear.

passage of fluid from the ear into the naso-pharynx ; and, secondly, either to promote absorption of the fluid in the ear, or to expel it. Preliminary treatment consists in the administration of a mercurial purge, followed by a saline draught. Inflation of the middle ear may be safely attempted in order to drive the fluid from the *cavum tympani* down the Eustachian tube into the naso-pharynx. The nasal detergent spray is helpful, and benzoic vapour (Appendix 41) should be inhaled and exhaled through the nose ; chloride of ammonium vapour may be substituted if the patient is unable to remain at home, as no patient ought to be allowed to go out-of-doors for at least one hour after the use of a warm vapour.

The surgical or immediate treatment consists in an incision of the drum, and the subsequent evacuation of the fluid from the middle ear by means of the air-douche or by suction. As a general rule, incision of the membrane is neither advisable nor necessary, for serous exudation does not tend to become purulent, and, except in the cases where considerable distension is found, it is only when a more speedy cure is demanded, or when the mucus is very thick and cannot be otherwise got rid of, that it is permissible ; but in the exceptional cases incision is imperative. (For a description of paracentesis, see p. 176.) Rather than the usual incision, it is advisable in this complaint to make a crescentic incision close to the lower edge of the drum, and as it is very difficult to dislodge this thick mucus, even through an opening so made, it will often be found necessary to insert a small fine probe with its extremity hooked, in order to extract the tenacious mucus which cannot be expelled by the air-douche. If an incision has been made, the after-treatment must be carried out with the strictest antiseptic precautions.

SEQUELÆ.—This serous catarrh of the middle ear tends by its recurrence to degenerate into a chronic condition, and forms one of the causes of chronic middle-ear inflammation.

CHAPTER VI

DISEASES OF THE MIDDLE EAR: CHRONIC NON-SUPPURATIVE

IT was customary until comparatively recent years to group under the comprehensive title of chronic dry catarrh at least two distinct affections. The combination of old observations with recent work now makes it possible to distinguish more clearly, and to describe with some accuracy, the two diseases to which we have referred—namely, a chronic catarrhal or subinflammatory process, termed 'otitis media chronica adhesiva,' and a specific condition, the origin of which is but partially understood—namely, otitis media sclerosa. As will be seen, these two complaints may coexist in the same patient, the one or the other predominating.

Otitis Media Chronica Adhesiva.

Chronic catarrhal otitis media—otitis media chronica adhesiva—is a progressive, insidious, and subinflammatory affection of the middle ear, consequent upon an extension of so-called catarrhal inflammation from the mucosa of the naso-pharyngeal space, which involves, firstly, the Eustachian tube, and eventually the middle ear. This disease is found at all periods of life, though it becomes more common as middle age approaches, and then diminishes in frequency. There is strong evidence that heredity plays

PLATE II

CHRONIC NON-SUPPURATIVE CONDITIONS

1. Right tympanic membrane: much **retraction of malleus** directly inward; cone of light almost absent; **crescentic** margin of membrane much thickened.
2. Irregular thickening of the drum.
3. Showing irregular retraction.
- 4, 5, 6, and 7. Irregular local retractions of membrane.
8. Handle appears to project beyond the **vertical line**; long process of incus visible posterior to malleus.
9. Excessive retraction of malleus, so that it lies **against the posterior fold**, here very white, prominent, and **distinct**.
10. Distension (aerial) of lower quadrants of membrane, the upper being calcareous.
11. Distension (aerial) of lower and posterior part of membrane after long employment of auto-inflation (Valsalva's method).
12. Calcareous degeneration of tympanic membrane, involving posterior segment, and a portion of anterior superior quadrant; the remainder of the membrane irregularly thickened.

PLATE II.



1



2



3



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5



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12

an important part in the production of this complaint, although in this instance the ancestral influence is more plainly noticeable in the tendency to the development of adenoid vegetations in the naso-pharynx. Heredity has also a share in the production of the highly-arched palate and narrow facial development, both of which tend to an undue contraction of the interior of the nose. The development of adenoid vegetations in the naso-pharynx is undoubtedly more common in civilized than in uncivilized races, and, consequently, as civilization advances in any race, so will the prevalence of adenoid vegetations become more marked, provided that at the same time the climate is such that the air is frequently highly charged with moisture.

COURSE AND SYMPTOMS.—The onset is gradual, and the affection is not infrequently at first unilateral, though after a certain lapse of time the other ear becomes involved. This, however, may not occur until the disease has obtained a considerable hold on the one first affected. The ear affected later is influenced by the tendency which exists for both sides to synergize in all those cases of middle-ear disease not due to the effects of suppuration. It will be noticed in all instances in which this sympathy occurs, whether in this disease or in others to be considered later, that the ear last affected is commonly the one least amenable to treatment. General conditions of the system, such as anaemia and gout, the effect of malarial poisoning, dyspepsia and constipation, all have unfavourable effects on patients suffering from this complaint. In common with other chronic non-suppurative diseases of the middle ear, the influence of obstructed nasal respiration, whether in the nose or naso-pharynx, is most marked.

Deafness and noises in the head are the principal symptoms of this disorder, to which in the later stages may be added vertigo. In the first instance, the patient will notice a transient deafness occurring whenever he is

afflicted with a nasal catarrh ; such an attack will present the symptoms alluded to under acute serous catarrh of the middle ear. The deafness may be accompanied by tinnitus, but the patient rarely seeks relief unless, on the subsidence of the catarrh, his hearing-power is diminished. When he does seek medical help, it is for symptoms due primarily to obstruction of the Eustachian tube, secondarily to the effects of this obstruction on the middle ear, or it may be to the consequences of inflammatory and sub-inflammatory attacks in the *cavum tympani*. Such results are the formation of adhesions and thickening of the mucosa, which interferes with the proper movements of the drum and ossicles, and passage of sound waves through the drum. Another illustration of these results is the excessive concavity of the drum and retraction of the malleus, together with contraction of the *tensor tympani* muscle and the ligaments of the malleo-incudal joint. The patient notices that after each successive cold, with its accompanying deafness, the tendency to recovery of the hearing is delayed, and eventually the recovery is not complete. The recovery of hearing after the cold is often ushered in by a sudden noise in the ear, frequently described as a loud report. This is due to the passage of air through the previously blocked Eustachian tube. The first indication that the hearing has not returned to the normal condition is a difficulty in grasping and comprehending general conversation, and perhaps a tendency to carefully present one ear to persons with whom the patient has to converse. This gradually increasing deafness may have existed for several years before he seeks relief—that is to say, before it has caused him any real inconvenience. Sufferers from this complaint, if previously possessed of a musical ear, will not infrequently suffer the most intense discomfort and annoyance from music which before had given them much pleasure, and sometimes these feelings become so great

that they are absolutely unable to listen to music in any form with satisfaction. This condition forms a variety of hyperesthesia acustica, and is often noted with other sounds besides those of music, especially in persons of a neurotic temperament. In the earlier stages of the disease deafness is very variable, disappearing frequently with a sudden noise like a small explosion, and varying with the state of the atmosphere, the patient frequently becoming deaf when the atmosphere is surcharged with moisture. Even in the earliest stages, however, if such a patient be examined carefully between the attacks, both subjective and objective symptoms may be demonstrated. The malleus will appear retracted, and the undue concavity of the membrane is demonstrated by an alteration in the cone of light. The tuning-fork test at this period will show a diminution of air-conduction, and a greater ability to hear noises than musical sounds. Occasional slight pain is complained of, either in the ear or behind it, though this is more frequently a dull ache than actual pain, and it may last for some time. It is never severe, and is more common in anaemic patients.

Autophonia (an undue perception of the sufferer's own voice), paracusis Willisii (the better appreciation of sounds in a noisy vehicle), and paracusis loci (the inability to locate sounds) are three symptoms which are frequently found in this complaint, though paracusis Willisii does not occur unless there are other conditions preventing the due movement of the ossicles, especially that of the stapes.

The tinnitus of which patients suffering from this disease complain is of a hissing or singing character, while an occasional variety of tinnitus, often a later symptom, is a loud musical and intermittent sound. Tinnitus is never constant in the earlier stages, and is not troublesome; but as the disease progresses it may become a never-ceasing and distressing factor. It increases in volume or intensity, and patients may complain that they are unable to sleep on

account of it, and that it is worse, or appears to them to be worse, at night or in the early morning. Mental and bodily fatigue, derangements of the general health, and stimulants (alcohol, coffee, etc.), are common causes of an accentuation of these irritating noises.

The tympanic membrane in simple adhesive or catarrhal otitis media is thickened, and appears whiter than normal, is cloudy or streaky, occasionally almost parchmentlike in appearance, though it may be thickened only in parts, and have areas of greater or less extent which remain un-



FIG. 30.—CALCAREOUS DEGENERATION OF THE TYMPANIC MEMBRANE.
C, Calcareous plaque.

affected. Should this be the case, these unaltered areas will usually be excessively depressed, and if they are of small size they will appear like dark holes in the mucous membrane (Plate II., Figs. 3, 4, 5, 6). Calcareous patches are frequently observed as well as patches of local atrophy, though whether these changes are due directly to the disease appears doubtful, since they are found in quite young children, and frequently in any portion of the membrane which may remain in conditions of suppurative otitis. The membrane is very rarely normal in appearance, and when so it does not possess the physiological curvature. In very severe or old-standing cases, the drum is at times

so retracted that in places no space exists between it and the inner tympanic wall; in fact, the membrane is sometimes seen tightly adherent to the inner wall.

As the inflation of the ear in this disease tends to improvement in hearing, patients not infrequently perform, either intentionally or by a violent blowing of the nose, Val-salva's experiment—*i.e.*, auto-inflation of the tympanum. If this act be frequently repeated, it may cause an undue distension of the more lax portion of the membrane in the posterior and upper segment, and so cause this area to appear to the observer after inflation as a convex protrusion, bleb-like in appearance, or, when the tympanum has not been inflated, as a concavity in which the membrane is lying upon the head of the stapes and long process of the incus.

The handle of the malleus occupies, in all but the earliest stages, an abnormal position—that is to say, it will either be retracted directly inwards so as to appear shortened to the observer, or it will approach the posterior edge of the tympanic membrane. In the former instance the retraction may be so great that the tip of the malleus comes in contact with the promontory, and, should it remain there for a sufficient length of time, will become firmly adherent, just as the tympanic membrane itself becomes attached to the long process of the incus under similar circumstances. When the malleus is drawn backwards, towards the posterior aspect of the membrane, it may occupy any position between the normal and one in contact with the posterior fold. The mobility of the malleus is tested by means of Siegel's speculum, which will show in every case that the range of movement is diminished, and that in a large number of instances this diminution has become absolute. It may be remarked again that the difficulty in appreciating absolute fixation of the malleus is due to the fact that the membrane moves freely over its upper two-thirds, and that the posterior segment bulges forward when

the air is rarefied, an appearance which is apt to convey the impression that the malleus itself is mobile. The cone of light in *otitis media chronica adhesiva* is never normal; it is altered both in direction and in form. It may be entirely absent from its proper situation, and replaced by a spot of light in an absolutely abnormal place. In such cases the membrane will lie almost entirely on the inner wall of the tympanum. In the earliest stages the cone forms a less obtuse angle with the handle than normal should this structure occupy a position more posteriorly than it ought; if the handle is retracted directly inwards, the cone of light becomes more horizontal than normal—in other words, the angle is rendered more acute. The cone of light itself will no longer reach to the periphery of the membrane. It may be broader than usual, may be divided into two parts, consisting of a bright point close to the umbo and a streak midway between this and the periphery, or it may be represented only by a bright spot at the tip of the malleus. In advanced stages the posterior fold of the membrane will be unduly prominent, appearing like a bright white crescent in those cases in which the handle of the malleus has a position of extreme retraction (Plate II., Fig. 9).

The causes of these changes in the tympanic membrane are twofold. The thickening of the drum is due to recurrent attacks of inflammation affecting its inner mucous surface, and the retraction of the membrane and alteration in the position of the handle of the malleus and of the cone of light are primarily due to the diminution of the atmospheric pressure within the tympanum, the external pressure remaining the same. Consequently the drum is, as it were, pressed inwards, for, during the obstruction of the Eustachian tube, the air contained within the *cavum tympani* becomes absorbed to a greater or less extent according to the duration of the obstruction. The subsequent contraction

of the tendon of the tensor tympani and of bands of adhesions within the tympanic cavity, as well as the contraction of the ligaments of the malleo, incudal and stapedial joints, and also the want of resilience in the tympanic membrane, all prevent spontaneous restoration of the drum to its normal condition.

The state of the Eustachian tube, as well as the condition of the nose and naso-pharynx, must be carefully noted. The patency of the Eustachian tube is determined by the effects of inflation upon the drum and by the sounds observed by means of the auscultatory tube. Inflation is always better performed through the catheter, as it enables the observer to hear more distinctly those sounds than when politzerization is employed. The sound heard through the catheter when inflating an ear affected with a catarrhal otitis media may be best described as distant and also as fine in volume; and here it should be remarked that a catheter of large calibre will permit a more accurate estimation to be made than does one of small size. Whatever catheter is used, the same calibre should be adhered to. The effect of inflating the tympanum will, except in the latest stages of this disease, give improvement in hearing-distance, an improvement which, though it varies according to the state of the *cavum tympani* and its contents, as well as to the amount of contraction and adhesions present, will probably be increased at each successive visit. The duration of this improvement will depend upon whether or not the tensor tympani tendon is permanently contracted and also upon whether there are many bands of adhesions fixed down the stapes. In all probability the degree of amelioration is influenced by the amount of contraction present in the ligaments of the small joints, demonstrated by the amount of mobility of the malleus exhibited with Siegel's speculum.

Tuning-fork tests, in the early stages, will show either normal bone conduction, or, more commonly, a slight

increase, less often a diminution. The increase in bone-conduction is often permanent in an uncomplicated case, being merely due to a slight but variable increase of pressure in the labyrinthine fluids without closure of the foramen rotundum. The air-conduction, by the tuning-fork tests, will be lowered to a greater or less extent, and the lower musical notes are lost in this disease, whilst the higher are longer preserved. If the disease be unilateral, Weber's test will show that the sound is referred to the diseased ear, though this test becomes useless when both ears are involved. The diminution in the upper part of the scale is best determined by that form of Galton's whistle called the 'Galton-Edelman whistle,' or 'Pfeiffer,' and will be found to be extremely slight; the loss of perception of the lower tones will be demonstrated by the use of low-pitched tuning-forks, and as a general rule, this loss increases with the progress of the disease. In the later stages, when the stapes is fixed in the foramen ovale, bone-conduction will be diminished to a moderate amount. Should secondary labyrinthine changes occur, bone-conduction will be much shortened, but in uncomplicated cases Rinne's test is negative. The watch or acoumeter will be heard at a shorter distance than usual and when inaudible on the mastoid will be heard when applied to some other part of the cranium, as the teeth or the zygoma.

If the stapes becomes ankylosed by fibrous or cicatricial tissue-formation with the niche of the fenestra ovalis the following signs, together with Gellé's test, will be valuable. These consist in a shortened bone-conduction, a markedly negative Rinne, together with extensive defect in air-conduction at the lower end of this scale.

Vertigo, or giddiness, is a late symptom of this disease but may become so severe and distressing that the patient have attacks markedly resembling those of Menière's disease (*vide* p. 213), and in which they may stagger or eve

fall down suddenly. A feeling of nausea is sometimes an accompaniment of these seizures. The uncertainty of these paroxysms in nervous patients tends to prevent their going out-of-doors unaccompanied, and often culminates in the condition known as agoraphobia, a condition aggravated by the deafness.

The nose and naso-pharynx always exhibit changes indicative of chronic inflammation. The nasal mucosa is hypertrophied, the nasal chambers irregular and narrowed, whilst the posterior extremities of the inferior turbinated bodies are usually hypertrophied to a greater or less extent. The naso-pharyngeal mucosa shares the hypertrophy, and is reddened, and in young persons adenoid vegetations are almost invariably present. Granular pharyngitis, or lateral pharyngitis, are rarely absent. Pregnancy appears to have an extremely deleterious influence in such cases.

DIAGNOSIS.—Diagnosis in this complaint, whilst simple in uncomplicated cases, becomes more and more difficult according as the disease is complicated with a greater or less amount of otosclerosis, and it has further to be distinguished from otosclerosis and those rare conditions in which obstruction of the Eustachian tube appears to have no permanent ill-effect upon the middle-ear structures, and is not accompanied by inflammatory action within the cavum tympani.

The objective appearances of the drum in this disease have been described. In uncomplicated cases of otosclerosis the drum is practically normal in colour and concavity; in its earlier stages a reddish blush appears in the region of the promontory. As there exists a large number of instances in which otitis media adhesiva and otosclerosis coexist, the border-line between these two diseases is hard to define with practical accuracy, and there is a large number of cases in which the appearance of the drum

will not render any valuable assistance, even though it may present the appearances considered pathognomonic of either. Reliance must be placed upon the tuning-fork tests as in true adhesive catarrh there is usually a tendency for the prolongation of bone-conduction in its earliest stages, and as the disease progresses, the tendency to a minus bone-conduction rarely becomes very pronounced; whereas in otosclerosis, from the moment the disease becomes capable of detection, bone- and air-conduction are diminished. In adhesive catarrh the Eustachian tubes are diminished in calibre while in otosclerosis they are more patent than normal.

TREATMENT.—The treatment will be considered under (1) administration of internal remedies, directed towards the relief or cure of the deafness and tinnitus; (2) the restoration of the permeability of the Eustachian tube and assistance in the return of the drum and middle ear to a condition of usefulness; and (3) the correction of abnormal condition in the nose and naso-pharynx.

Administration of Drugs.—The remedy most generally serviceable is strychnia. It should be administered in doses of increasing strength, commencing with $\frac{5}{100}$ grain in the female and $\frac{6}{100}$ to $\frac{7}{100}$ grain in the male, augmenting the dose by $\frac{1}{100}$ grain every second or third day, either until the limit of toleration is reached, or until the patient is taking a dose of $\frac{10}{100}$ to $\frac{12}{100}$ grain three times a day according to the sex. This remedy will be found extremely useful both in improving the hearing power and in diminishing tinnitus in a large number of cases. Where this drug fails to relieve the tinnitus, dilute hydrobromic acid in $\frac{1}{2}$ or 1 drachm dose three times a day, either alone or combined with strychnine is occasionally helpful; and as an alternative bromides may be administered at night.

Another very serviceable remedy for the relief of subjective noises is valerian administered in full doses, and best in the form of ammoniated tincture; whilst in anaemia

patients arsenic or iron is indicated, and in gouty patients citrate of lithia and the daily use of Carlsbad salts. At the same time any digestive disturbances must be attended to.

The only articles of diet which appear to be detrimental are coffee, alcohol, and, perhaps, pepper. Excessive cigarette smoking should be prohibited.

Inflation.—In the majority of cases, especially in the earlier stages of the disease, the major part of any improvement is effected by the use of periodic inflation. To obtain this end there are three recognised methods: that of auto-inflation—the process of Valsalva—politzerization, and inflation through the catheter.

With regard to auto-inflation, it should *never* be prescribed, as the relief obtained by the patients induces them to repeat the process with ever-increasing frequency, and in a considerable number of cases it has a very deleterious effect, stretching unduly the posterior segment of the drum. It will eventually cause increased hardness of hearing by the relaxed tissues falling and lying upon the long process of the incus and the head of the stapes.

Whether politzerization or catheterization is resorted to must depend to a certain extent upon the skill of the operator, but the use of the catheter enables a more accurate employment of the air-current.

The ear should be inflated not oftener than three times a week, and persisted in for about six weeks, or less if the patient ceases to improve. The course of inflation is to be repeated at the expiration of about four weeks, and may be continued as long as improvement is manifest. After this second course of treatment, or sometimes at the end of the first period, the patient will have obtained what may be termed his maximum amount of hearing. This amount of hearing is retained for a longer or shorter period, and he should be instructed to immediately return for treatment at the first indication that he is again becoming deaf. The

intervals at which the patient returns will, in favourable cases, rapidly increase, and eventually the patient will remain stationary for several years at a time.

Should no improvement be obtained after two weeks' treatment, no good effect is likely to be produced by continuing inflation for a longer period; but if no beneficial effect accrues, other adjuncts to this treatment may be employed. These are the injection through the catheter into the middle ear of oily fluids, or aqueous solutions and vapours. Of the former, highly rectified paraffin, petroleum molle, either alone or containing iodine or menthol in solution, the former in the strength of $\frac{1}{2}$ per cent. and the latter of 1 per cent. Of the fluids, solutions of iodide of potassium and bicarbonate of soda, 1 and 5 per cent. solutions respectively, with or without the addition of a little glycerine, are the most useful.

The method of employing these remedies is as follows: The catheter having been passed and ascertained to be in position by a preliminary use of the air-bag, 1 to 3 minims of the fluid selected are injected into the catheter from a Pravaz syringe, and the air-bag again employed. If as small an amount as this is used, it is blown out of the distal end of the catheter in the form of a spray, and will penetrate and permeate the whole cavity of the middle ear. If more fluid is used, the major part of it will find its way down the Eustachian tube, and that which is driven into the tympanum will gravitate to the bottom of the cavum tympani, and as long as it remains there will cause a temporary increase of deafness, and is not productive of any better results than when the smaller amount is employed. These solutions should be employed each time the catheter is used—that is to say, three times a week.

It is in certain conditions of adhesive middle-ear disease that the Eustachian bougie gives very good results. The indications for its use are the bad entry of air into the middle

ear when inflating through the catheter, and improvement in the hearing, but only of short duration, after inflation. The bougie should be used two or three times, and the largest size employed and kept *in situ* for three to five minutes each sitting, and a little oleum petrol injected as described on the previous page.

Vapours.—The following vapours are employed cold, advantage being taken of their volatility: acetic ether, ethyl iodide, and ethyl chloride; they are used either alone or mixed with acetic ether and tincture of iodine, a few minims being dropped into the air-bag before inflation. This is a proceeding often of considerable benefit in the special treatment of tinnitus.

Nascent ammonium chloride vapour inhaled or exhaled through the nose, or taken into the mouth and passed through the nose, acts locally on the naso-pharyngeal mucous membrane; by reducing or curing the catarrhal state of this region it often improves hearing, and may be safely recommended.

Methods of Treatment from Without.—The foregoing methods may be considered as treatment from within, inasmuch as they act on the cavum tympani and on the inner surface of the membrana tympani. Those about to be considered are employed on its outer surface via the external auditory meatus. They are rarefaction of the air in the external meatus, pneumo-massage, and the use of the pressure-probe of Lucae.

The rarefaction of air in the external meatus is a proceeding which is often of considerable benefit, contributing towards the more forcible stretching of adhesions between the membrane and the inner wall of the tympanic cavity, and also aiding in the stretching of the contracted tendon of the tensor tympani. This method is particularly valuable, in common with the use of the pressure-probe, in cases where the handle of the malleus is partially or entirely fixed. The

method of rarefying the air in the external meatus is by the use of the raréfacteur of Delstanche, or, by what is equally effective, the insertion of the rubber nozzle of a compressed Politzer's bag into the external meatus, and allowing it to partly expand. Whichever form is used, great care must be taken that the suction is not too violent. The best method of controlling this suction is by attaching the raréfacteur to a Siegel's speculum, observing the effect on the drum, and regulating the pressure according to the effects observed. The dangers to be apprehended are rupture of a bloodvessel in the membrane, or rupture of the membrane itself. The former is a matter of no permanent moment, but will delay the local treatment for some time, and may cause more pain than is desirable; while rupture of the membrane itself is a much more serious consequence, since, should it be neglected suppuration may ensue, and the case become converted into one of suppuration in the middle ear, with all its attendant dangers. If this form of treatment prove beneficial, it should be repeated daily for some time, and may be delegated to the patient's own use, provided that he is carefully instructed as to the necessity of avoiding any effect exceeding slight discomfort from the amount of suction employed. The séances should not exceed half to one minute to commence with, and twenty minutes at the outside when the ear has become tolerant of the strain.

The use of Lucae's pressure-probe is described on p. 63. It is well to anæsthetize the ear by the use of the aniline or cocaine solution. The pressure should be intermittent, and not repeated until any inflammatory disturbance that may have been caused by its use has subsided, nor should it be employed for more than a few minutes at a time. The total duration of the course must be determined by results.

Oto-massage or pneumo-massage is described on p. 63. It may be employed daily, and is well managed by patients themselves. It should not be used at first for a longer

duration than one minute, and should not be persisted in without a relatively long period of disuse of more than four weeks.

The use of these methods is occasionally followed by a diminution of the hearing power, which must be taken as an indication for the prompt discontinuance of the treatment; the hearing power will then not be rendered worse.

Fixation or immobility of the malleus is a serious condition, and after attempts at mobilization have been made and failed there remains only one method more, viz., operation. The operation consists in making an incision through the membrane and passing behind it a short-bladed knife, with the blade at right angles to the shaft, and separating any adhesions between the handle of the malleus and the promontory, and then drawing the malleus forcibly into position. The constant use of inflation for some weeks subsequently will often secure a marked improvement in the hearing.

Otosclerosis, or Chronic Sclerosis of the Middle Ear.

Otosclerosis, like the adhesive catarrh, is a progressive subinflammatory affection. Its etiology at the present time is not clearly determined, but in a very large number of instances at least it is concomitant with and part of a general sclerosis of the submucous tissues of the respiratory tract, of which the Eustachian tube and middle ear⁶ are diverticula. This pathological condition is frequently influenced by, or is dependent on, hereditary syphilis, while heredity itself, apart from the specific taint, exercises a baneful influence in a large proportion of cases. The sclerotic condition alluded to commences at the orifice of the respiratory tract—that is to say, at the anterior nares—and on examination of the nasal chambers by anterior rhinoscopy the mucosa presents appearances characteristic of rhinitis sicca. This condition extends into the nasopharynx and down the posterior wall of the oro-pharynx,

and is said to extend as far as the submucous tissue of the finest ramifications of the bronchi. At first sight the nose may be described as looking healthy, but closer inspection shows the mucous membrane abnormally red and dry, while the patients rarely, if ever, suffer from nasal catarrh, or require to use a handkerchief. In mixed cases various forms of nasal obstruction are found, as in adhesive otitis media. Atrophic rhinitis and atrophic naso-pharyngitis are frequently associated with deafness caused by otosclerosis. In the ear itself the earliest condition known is muco-periostitis of the inner wall of the tympanum, which may be recognised by the presence of a pinkish blush or reflex in the region of the promontory, and seen through the normal tympanic membrane below and behind the tip of the handle of the malleus.

The pathological observations on record, from which we are able to arrive at a knowledge of the morbid changes which occur during the progress of this disease, mostly deal with cases in which the disease has already attained some degree of severity. They show two distinct changes, one class being the development of patches of osteoporosis or rarefaction, which are found in various parts of the labyrinthine capsule, viz., in the promontory, in the neighbourhood of the fenestræ, and in the modiolus of the cochlea. The other series of changes consists in the formation of osteophytes in the environment of the oval window, both intratympanic and intralabyrinthine; the intratympanic osteophytes causing fixation of the stapes, while the intralabyrinthine osteophytes will directly affect the intralabyrinthine pressure, and thus materially interfere with the auditory function. Besides this, ossification of the annular ligament around the foot plate of the stapes takes place in the latter pathological state.

The disease is found even in early childhood, but appears more frequently in young adult life, especially in anæmic males.

DOSE AND SYMPTOMS.—The onset of the disease is

usually gradual, but may be comparatively rapid. It may steadily progress or may be intermittent, and, again, may remain stationary for a long period of years, this period of rest being usually followed by a sudden increase in deafness. No known cause appears to influence its progress. When the disease occurs in children, it is frequently accompanied by the presence of adenoid vegetations in the naso-pharynx, and it is due to this early condition of otosclerosis that in a considerable number of cases the removal of adenoid vegetations for deafness is not followed by any improvement in hearing. The disease is sometimes unilateral at its commencement, but more usually bilateral, and it rarely remains one-sided for any length of time.

The chief symptom is deafness, tending to increase, and remarkably uninfluenced by inflation of the middle ear. Tinnitus usually is an early symptom, and may be complained of before deafness is noticed. It increases in severity with the progress of the disease, and becomes an intolerable annoyance and a source of grave discomfort to the patient, more so, in fact, than is common in any other form of middle-ear disease. It naturally influences most those patients whose habits of life or temperament render them more liable to nervous disturbance. As distinguished from the noises complained of in adhesive disease of the middle ear and other external and middle-ear disorders, patients suffering from otosclerosis most frequently refer them to the head rather than to the ear.

As subsidiary symptoms, a feeling of dulness, or occasional pain and aching in the ear, may be complained of, especially in the earlier stages. Deafness, like that of other middle-ear diseases, is more noticeable at first in general conversation, but musical sounds are not usually perverted. Paracusis Willii is a more frequent symptom than in adhesive catarrh, being due to the frequency with which the stapes is ankylosed.

Tuning-fork Tests.—The bone-conduction is diminished and the air-conduction very much diminished and may be quite absent. If new bone should be thrown out within the cochlea or if the disease be complicated by secondary internal ear lesions, bone conduction will be diminished. It is well to know that Rinne's test, which is negative in this disease may be either total or partial. By this is meant that if a tuning-fork of a pitch below C¹, as well as a fork of higher pitch is employed, the result will be negative in both cases; but if it is partial, the higher-pitched tuning-fork may give a positive result. Gellé's test is valuable in demonstrating the fixation of the stapes—that is to say, if Rinne's test is negative up to C¹, and Gellé's is also negative, then the stapes is ankylosed. If Rinne's is negative below C¹ and positive above, then Gellé's test decides the question as to whether the stapes is ankylosed or not.

The condition of the membrana tympani in uncomplicated cases is markedly different from the condition observed in adhesive catarrh. There is little, if any, retraction of the membrane, which is more translucent than normal, the subjacent structures and contents of the cavum tympani being frequently distinguishable to a greater or less extent, and at the earlier stages, as previously noted, there is a pinkish blush over the promontory. When, however, otosclerosis is complicated with adhesive catarrh, the membrane may present any appearance between the two extremes. The external meatus is often singularly devoid of cerumen, pale in appearance, with a tendency to exhibit a polished surface, and not infrequently it appears rather larger in calibre than normal. This is due to an extension of the disease to the subepithelial tissues of the external meatus.

The fact has already been stated that, in a large number of cases of otosclerosis, the nasal passages are unusually free, and present the signs of rhinitis sicca; however, where this condition of the nose does not exist, and where there is

a certain amount of nasal obstruction, the same patency of the Eustachian tubes is present. This fact is of great diagnostic value. The tube is abnormally free; on inflation with a catheter or with Politzer's bag, the air is heard to rush into the middle ear with a large stream and without any hindrance, also rarely with any relief of the deafness; if the disease is of any duration, patients not infrequently state that they only hear, but do not feel, the air entering the *cavum tympani*.

PROGNOSIS.—This is very unfavourable. In a certain number of cases the morbid processes remain stationary for a long period of time, though the general tendency of the disorder is to become markedly worse; careful treatment will no doubt enable the surgeon in a large number of instances to obtain a certain amount of relief, or, at least, to retard the march of the symptoms.

TREATMENT.—First, with regard to the use of the Eustachian catheter and inflation in uncomplicated cases. This method of treatment will not only be unattended by any benefit, but is by no means infrequently followed by a temporary increase of deafness. When, however, the case is one of mixed otosclerosis and adhesive otitis media, the use of the catheter may be productive of a slight improvement.

The use of guttæ of various sorts is occasionally productive of good. Those most to be recommended are: Odourless paraffin; $\frac{1}{2}$ per cent. iodine in the same oil; solutions of iodide of potassium, 5 grains to the ounce. These guttæ should be introduced into the catheter and blown into the middle ear once or twice a week for several weeks (about six).

Of other local measures, oto-massage is always to be practised, unless after the first application it is attended by a diminution in the hearing-power. It should be employed daily, commencing with a period of about half a minute, which may be gradually increased to five minutes, *per diem*. The rapidity of the vibrations is not of such great importance as the strength of the pull—that is to say, a light pull

should be employed, and a very high number of revolutions per second may be safely used.

It is from internal remedies that the greatest benefit is to be derived in pure cases of otosclerosis. If the case, however, is one in which this disease is combined with adhesive otitis media (non-suppurative), oto-massage is likely to increase the good effects derived from these remedies. One hopes most from the administration of phosphorus. This should be administered with caution and in an oily solution ($\frac{1}{10}$ per cent. in oil or *mistura amygdalæ*), and be given three times a day after food, commencing with 10 minims, and gradually increasing the dose to 45 minims. If, however, stomachic disturbances are produced, the drug should be given in keratin or glutin capsules. Besides this, we have the following remedies, which may prove serviceable: Iodide of potassium should be administered in doses of 3 to 5 grains in $\frac{1}{2}$ pint of hot water directly after meals. In anæmic cases the syrup of the iodide of iron may be substituted for the potassium salt with advantage. When mercury is administered, as it always should be if there is the least suspicion of inherited syphilis, it may be given as the perchloride or biniodide, the latter in the form of a pill, the former in combination with cinchona (*vide* Appendix). In the latter prescription it will be found that the two may be combined without any deposit being formed.

OPERATIVE TREATMENT OF TINNITUS.—Mobilization of the stapes, trephining of the promontory, excision of the tympanic membrane and ossicles, and the radical mastoid operation, have all had their advocates, as has also the extraction of the stapes. Unfortunately, the results of none of these operations justify their being recommended for adoption.

Eustachian Tube Obstruction.

Obstruction of the Eustachian tube, of an acute or chronic nature, without material involvement of the middle

ear, is a by no means infrequent cause of deafness. In both varieties the origin of the impaired patency of the tube is either occlusion at the orifice, more or less complete, from adenoid vegetations in the naso-pharynx, or from inflammatory swelling of its lining membrane, consequent upon an extension of inflammation from one structure or another in the naso-pharynx. In the acute cases the mucous membrane and submucosa of the tube are infiltrated with small cells and serum. In the chronic cases the small-celled infiltration has become organized, and a fibrous stricture remains. When the obstruction is intratubal, the site of contraction is rarely at the orifice, even in the acute cases, but is usually found at the outer extremity of the cartilaginous tube, at its junction with the osseous portion.

Acute Eustachian Obstruction.—The symptoms are distinctive. After a slight cold the patient notices sudden deafness, which is usually unilateral. He may complain of a feeling also of numbness with fulness in the affected ear, and when the hearing returns its restoration is preceded by a pop in the ear.

OBJECTIVE SIGNS.—When the tympanic membrane is examined, the cone of light is usually found slightly higher than normal, and incomplete at its outer extremity. The handle of the malleus will be slightly injected, and the lining membrane of the inner wall of the tympanic cavity is commonly seen through the drum as a dull red reflex. The tympanic condition, in fact, is one which, had it been slightly more pronounced, would have caused serous effusion into the tympanum. This form of obstruction is apt to recur at intervals, and, like the serous catarrh, tends to produce an adhesive otitis media, or to obliterate more or less perfectly the Eustachian tube, merging into a chronic condition.

TREATMENT.—As in most acute inflammatory conditions,

a brisk mercurial purge is valuable; a sedative vapour such as that from the compound tincture of benzoin, is also very helpful, the patient inhaling the vapour through the nose. This inhalation should be repeated at intervals of four hours during the day, and the patient is better confined to the house. At the expiration of a few days, when the patency of the Eustachian tube is usually re-established inflation of the middle ear should be employed bi-weekly for a few weeks, even though the hearing is entirely restored; for by this means subsequent attacks will cause less injury to the intratympanic structures, as the tendon of the tensor tympani will thus have been prevented from undergoing contraction. At the same time a very careful examination of the nose and naso-pharynx should be made and as far as possible a prophylactic treatment adopted—i.e. one which aims primarily at obtaining a free air-way in the inferior meatus.

The presence of adenoid vegetations in the naso-pharynx, if the growth interferes mechanically with the normal opening of the tube, will cause symptoms of obstruction, usually of a chronic character; but if the growth is rapid, comparatively sudden deafness will be produced.

Chronic Obstruction.—Chronic obstruction of the Eustachian tube is a very frequent concomitant of the adhesive form of chronic middle-ear disease, and its presence materially contributes to the extreme retraction of the drum seen in some of these cases. In fact, an extreme retraction of the membrane is the chief sign of an old-standing contraction of the Eustachian tube; in a certain proportion of cases, however, the stricture of the tube forms the most important part of the disease, and when the patency of the canal is restored a great improvement in hearing is almost immediately noticed.

DIAGNOSIS.—In all forms of tubal obstruction a diagnosis is made partly from the appearance of the drum, but principally

pally from the sound obtained by using the Eustachian catheter; when the tube is obstructed the sound is small, distant, and sibilant; whilst, with a free tube, as has been mentioned, the sound is full and near.

TREATMENT.—The treatment which yields the most satisfactory result is the regular use of the Eustachian bougie. These are made of celluloid or whalebone, and may be passed two or three times a week until the tube remains free. (The use of the bougie is described on page 122.) The bougie should be left *in situ* for from two to five minutes, and it is always advisable to pass the largest size possible. Besides the use of flexible bougies the practitioner may employ electrolysis. The external meatus is filled with water, and the negative pole placed within the meatus, while the positive pole is connected with a fine vulcanite bougie tipped with metal. The current must be turned on very gradually, and not kept on for more than three minutes; care must be exercised in breaking the flow of the current, since rapidly disconnecting the poles is apt to cause a severe vertigo. The most suitable strength of the current is about 5 milliampères. As an adjunct to this mode of treatment the naso-pharynx should be painted after each sitting with Mandl's weak solution (Appendix 37).

CHAPTER VII

CHRONIC SUPPURATIVE DISEASES OF THE MIDDLE EAR

Chronic Suppuration of the Middle Ear—Otitis Media Suppurativa Chronicā

SUPPURATION of the middle ear is by general consent considered chronic after it has been in existence for more than six weeks. This is a purely arbitrary division, but in practice some such fixed period of time is advisable. It may, therefore, be viewed as the sequel to an acute middle ear suppuration which has ceased to show any evidence of active inflammation. No doubt isolated cases occur in which the acute disease lasts considerably longer than the time given. Tuberculosis is the most important cause of such continuance, and this variety has been considered under the heading of Acute Tuberculous Disease of the Middle Ear (p. 103).

As has been seen, all chronic otorrhœas which have their source in the middle ear are the sequels to inflammatory disorders of the nose and naso-pharynx. Infantile otorrhœa is most commonly, one can almost say invariably, accompanied by swelling of the pharyngeal tonsil, and it is to the persistence of this enlargement that the continuance of middle-ear suppuration in childhood is largely due. In adults it is less common for a primarily acute inflammation to merge into a chronic one, chiefly for the reasons that it is more

PLATE III

CHRONIC SUPPURATIVE CONDITIONS

1. Perforation in posterior superior quadrant, through which stapes fenestra rotundum are visible; anterior segment calcareous.
2. Perforation in inferior segment.
3. Cholesteatomatous concretion behind membrane at upper back part; due to old suppuration.
4. Granulations filling anterior segment of tympanic cavity.
5. Scar membrane, recent.
6. Destruction of inferior segment and also of posterior superior quadrant: head of stapes, stapedius tendon, fenestra rotunda and promontory visible.
7. Perforation in posterior segment: stapes, stapedius tendon, and fenestra rotundum exposed.
8. Perforation in anterior inferior segment.
9. Perforation in posterior inferior segment: fenestra rotunda visible.
10. Perforation in Shrapnell's membrane, with small pendulous polypus hanging through.
- 11 and 12. Perforations in Shrapnell's membrane: in 12, remains of the head and neck of the malleus are seen.

PLATE III.



1



2



3



4



5



6



7



8



9



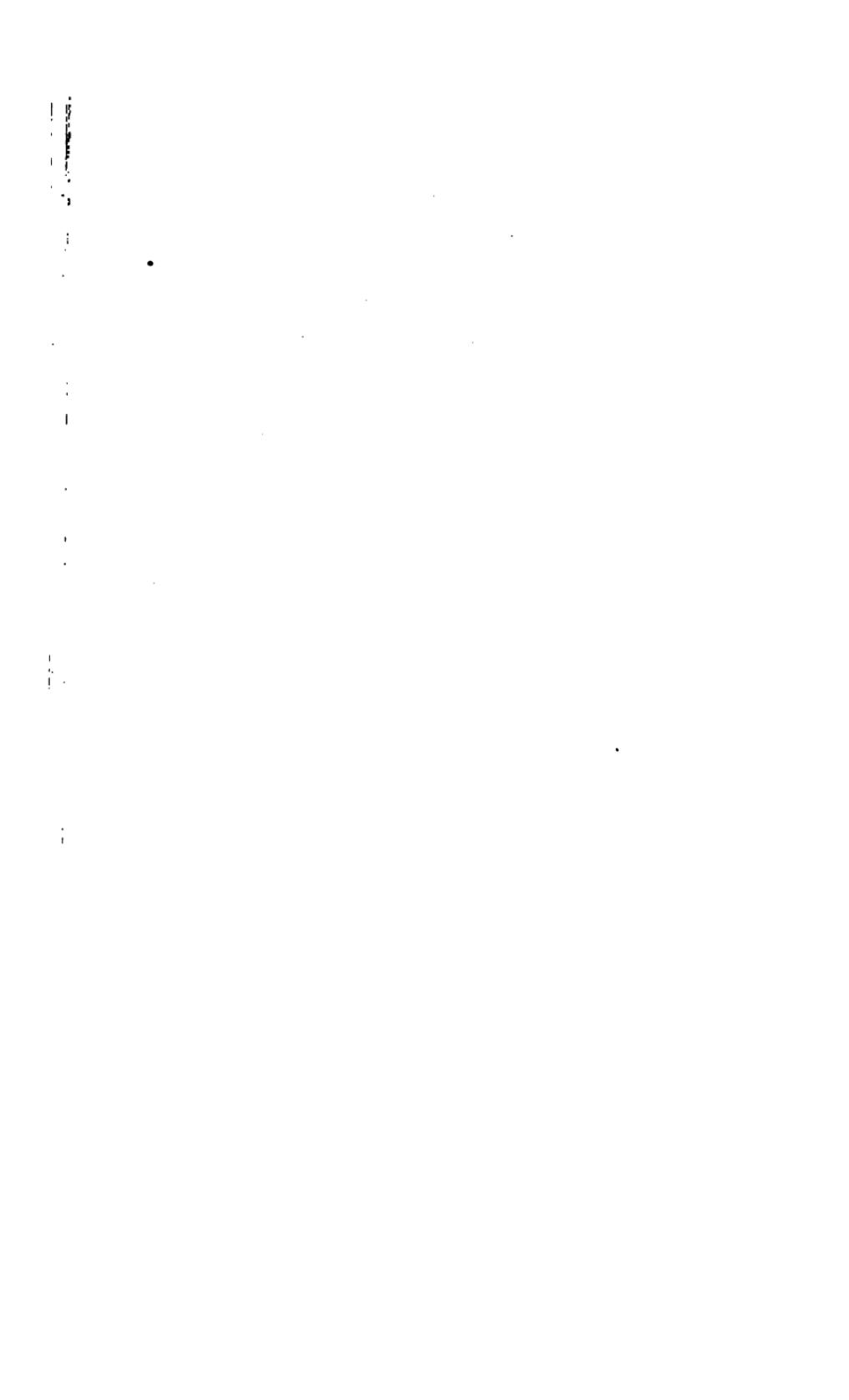
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11



12



easily and efficiently treated, and that the pharyngeal tonsil is rarely hypertrophied, so that the middle ear drains freely into the naso-pharynx. In Figure 31 is given a diagrammatic representation of a section through the external meatus, middle ear, and Eustachian tube. From this it will be seen how the drainage of the middle ear is performed by the Eustachian tube. If the Eustachian tube is unable to perform this function on account of its orifice being closed by pressure from adenoid growth in the naso-pharynx, and if there is at the same time suppuration in the middle

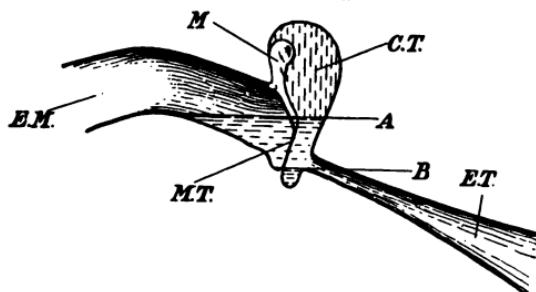


FIG. 31.—DIAGRAM ILLUSTRATING THE INFLUENCE OF ADENOID VEGE-TATIONS IN THE NASO-PHARYNX ON SUPPURATION IN MIDDLE EAR.

EM, External meatus; **M**, malleus; **MT**, tympanic membrane; **ET**, Eustachian tube; **A**, level of fluid in external meatus and cavum tympani; **B**, level of fluid in ear when Eustachian tube is patent; **CT**, cavum tympani.

ear and its secondary cavities, an accumulation of pus will occur within the cavity of the middle ear. Until the retained secretion has reached in the first instance the lower border of the tympanic perforation, wheresoever this may be situated, and until in the second place the pus has escaped through the perforation into the external meatus, it will only escape when it has reached the level of the highest point in the floor of the external canal; if the perforation lies below this level, the whole cavum tympani may be constantly full of pus.

SYMPTOMS AND SIGNS.—Purulent discharge, sometimes offensive, occasionally stained with blood, from the external

meatus; perforation of the membrana tympani; deafness. Patients often complain of giddiness, a disagreeable taste in the mouth, noises in the ear, headache (general or localized), and an irritability of temper. They are not uncommonly unable to concentrate their thoughts upon any subject. In long-standing cases, or in cases where suppuration is proceeding rapidly, other symptoms may be noticed, and they are usually of serious import. Fixed pain in the ear or over a localized portion of the mastoid, nystagmus, inexplicable vomiting and facial paralysis, may be instanced in this connection.

Discharge.—Though usually purulent, it may be quite clear and watery. An offensive odour is often very noticeable, and the quantity of the discharge varies within wide limits, from a scarcely perceptible moisture of the meatus to a profuse flow. Its consistency may be increased so much as to resemble treacle in this respect.

Intermittent discharge may be due to a lighting up of the old trouble after a temporary cessation, or to some temporary obstruction to the outlet of pus, in which case exacerbations of pain are frequent. In such cases a recurrent discharge is usually preceded by either ear-pain or headache. A sudden cessation of discharge is sometimes a prelude to, or often occurs simultaneously with, some of the severe septic intracranial lesions.

Perforation of the Membrana Tympani.—It must not be taken as a *sine qua non* that there should be in every case of suppurative otitis media a perforation of the membrana tympani, but the instances in which there is no perforation are of very considerable rarity. In place of the perforation in the membrane a sinus opening into the external meatus is present which is connected directly or indirectly with the cavity of the middle ear.

When a perforation is present its size and situation varies. The drum is rarely absolutely destroyed, for, even in those

cases in which the greatest destruction of the membrana tympani has taken place, there is a part, at least, of a narrow border left at the periphery, where the membrane is strengthened by the presence of a few cartilage-cells, and also where its nutrition is greatest.

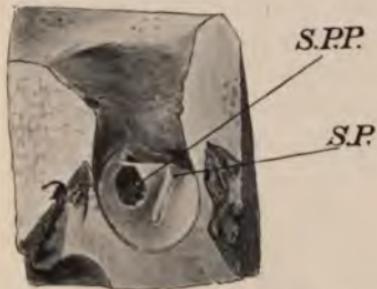


FIG. 32.—PERFORATION OF MEMBRANE IN POSTERIOR SUPERIOR QUADRANT.

SPP, Perforation in superior posterior quadrant; *SP*, processus brevis.

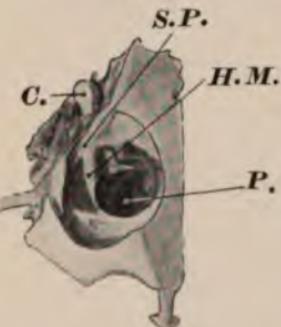


FIG. 33.—PERFORATION OF MEMBRANE IN POSTERIOR INFERIOR QUADRANT.

C, Head of malleus; *SP*, processus brevis; *HM*, handle of malleus; *P*, perforation.

Cases of perforation of the membrana tympani may be conveniently divided into two great classes—perforation of the membrana propria, or the true drum, and perforations of the membrana flaccida, or Shrapnell's membrane (*vide p. 142*).

Perforations of the true drum differ in import according to their situation. They may be said to increase in seriousness when, considering those situated in the anterior superior quadrant as the least serious, they are taken in the following order, passing round the drum : Anterior superior, anterior inferior, posterior inferior, posterior superior. This seriousness of import is applicable as regards the prospects of cure, hearing power, and the extent of the destruction of structures within the middle ear. In order to obtain a clear view of the membrane it is necessary to

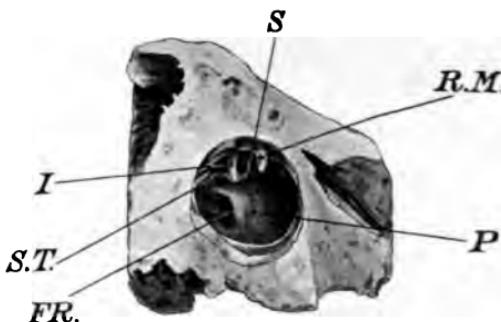


FIG. 34.—TOTAL DESTRUCTION OF MEMBRANE AND HANDLE OF MALLEUS.

RM, Remainder of malleus with a filament of tympanic membrane attached; *S*, stapes; *I*, incus; *ST*, stapedius tendon; *FR*, foramen rotundum; *P*, promontory.

remove from the external meatus all traces of pus, epithelial débris, or wax. This may be accomplished either by gently syringing the ear with an antiseptic solution, which is best done with an indiarubber tube fitted to the nozzle of the syringe, or by means of cotton-wool mops. The patient should invariably be seated, the solution of a comfortable temperature, and no force imparted to the stream of lotion. Even with these precautions severe vertigo will occasionally be complained of; it passes off in a short time. If cotton-wool mops are employed, they should be attached to

a proper carrier ; and to avoid soiling the fingers the used wool may be removed either by a dentist's wool-receiver or by a pair of forceps. Brisk movement of the mop in water loosens its attachment to the carrier and facilitates detachment. When the passage has been carefully cleansed, all moisture must be removed by pledges of cotton-wool, as was described under general treatment.

It is well to remember that, as a result of either method of cleansing the ear, the tissues of the drum and deeper parts of the meatus will be somewhat injected, and proper allowance must be made for this hyperæmia. If the perforation is large it is easily detected. When suppuration is profuse a drop of pus may be frequently seen oozing from the perforation, and at times a distinct pulsation is noticed in the exudation. This phenomenon has been considered of some importance as indicating the presence of complications. Should, however, the perforation be not clearly discernible, inflation of the middle ear by means of the catheter or bag, and the use of the auscultatory tube will give definite information as to its presence, though not as to its situation ; either a slight whistling sound will be heard, or, if the perforation is relatively large, the air-current will impinge directly on the ear of the observer. Perforations, if large, enable the observer in the majority of instances to see a part of the inner wall of the tympanum. The part seen will necessarily depend upon the site of the perforation. If it is situated in the posterior inferior portion he will see the promontory, and perhaps the foramen rotundum, appearing as a dark shadow posteriorly. If the posterior superior quadrant is gone, or if the perforation embraces that area, he may see the long process of the incus, the stapedius tendon, and occasionally the bony prominence of the Fallopian canal. In a case of long-standing suppuration the mucous membrane of the inner tympanic wall will have a pale yellow colour, or it may appear flaky white

when it is undergoing the so-called cholesteatomatous change. If the case is more recent, or the disease more active, the mucous membrane will appear pink, and should there be a tendency to granulation, nodes may be observed on it not unlike the surface of a raspberry, but of a brighter red hue. When the perforation is small, so that little light is able to penetrate through it into the cavity of the middle ear, the perforation appears as a dark point ; to distinguish it from a depressed area of attenuated drum membrane, there will be no minute light reflex visible within it, as there usually is in such a condition of the membrane, but the use of Siegel's speculum or the inflation test will render the diagnosis clear. The edges of the perforation convey valuable hints upon the state of the case. If the perforation has existed for a considerable period, and the discharge is not of a very irritating character, the edges will be thickened and callous. Provided there is a tendency to the closure of the perforation, or if the discharge is of a very irritating character, the edges will be pink and thin ; at other times the margins will be sharply cut, this sharpness of definition being usually met with in perforations in which the discharge is either slight in amount or has not existed for long periods.

Perforations in the drum are usually single, but occasionally there are more than one, and in many instances a second perforation lies in Shrapnell's membrane ; in other cases what was originally a single perforation has been converted into two or more by bridges of tissue having grown across the space.

Perforations in the posterior superior quadrant are often very difficult to detect, sometimes because they are so situated at the edge of the membrane that they are hidden by the posterior part of the meatus ; if their presence is suspected, the upturned edge of a Hartmann's probe will afford conclusive evidence, or a tiny speck of moisture may

be seen on the upper part of the membrane. In a large number of cases this is not a perforation of the *membrana tympani* in the usually accepted sense of the word, for cicatricial tissue binds down the edges of the membranous portions of the perforation to the inner tympanic wall and posterior wall of the aditus, so that pus from the antrum flows directly into the external meatus without actually reaching the cavity of the middle ear.

The risk of injury and destruction of any link of the ossicular chain varies both with the duration and with the situation of the perforation in the membrane, one in front of or below the handle of the malleus being comparatively rarely accompanied by necrosis or caries of the ossicles. A perforation of any duration situated in the posterior superior quadrant is invariably accompanied by a carious destruction of osseous structures; the long process of the incus, the inco-stapedial joint, the stapes itself, or both the stapes and the long process of the incus, being the parts frequently affected. A perforation of Shrapnell's membrane, which has existed for even a comparatively short time, will be accompanied by destruction of the malleo-incudal joint; with a perforation in this region which has existed for some months or more the head of the malleus and the body of the incus will be more or less destroyed, and in rare instances, where a long-standing suppuration in this region has been cured, the malleus and incus will have become ossified together. In Fig. 37 will be seen a diagrammatic representation of the frequency with which various parts of the ossicles are destroyed. In some cases of extensive destruction of Shrapnell's membrane the incus may be entirely destroyed, and only the handle of the malleus left. A useful method of ascertaining whether or not the ossicular chain is complete is that, devised by Cheatle, of gently stroking the drum with a fine probe, when, if the ossicular chain is complete, a friction sound is heard;

if the chain is incomplete, the movement of the probe alone is felt.

COURSE.—The course of chronic otorrhœa cannot be said to tend towards spontaneous cure. Permanent cessation of discharge comes about in an extremely small proportion of cases. Cure can be obtained by careful treatment in a fair number of the cases which come under observation; the great majority, however, tend to continue or relapse, and of this large class few fail to exhibit complications at one time or another.

The complications, to which reference will shortly be made, may be divided into those which are only hurtful so far as the organ of hearing itself is concerned, and those which, if left untreated, may sooner or later end fatally. As will be seen after a consideration of the possible complications of the disease, no case of discharge from the middle ear should be left without careful and continuous treatment upon ordinary lines; and if a cure cannot be obtained in this way, in no instance should the patient be allowed to continue without having the dangers of his position and the advantages to be derived from operative procedures clearly placed before him.

Chronic Suppuration of the Tympanic Attic.

Chronic suppuration in this situation is recognised by the presence of a perforation in Shrapnell's membrane, together with a history of chronic discharges. Frequently these perforations are partially closed by epithelial débris, and from them at times one or more small polypi may be seen protruding (Pl. III., Fig. 10). In order to confirm the diagnosis the bent end of a Hartmann's probe may be introduced through the perforation, and bare bone sought for at the same time. Perforations in this locality may have existed for a number of years with an exceedingly small amount of disturbance to the hearing power, and it is

due to this fact that patients suffering from chronic disease of the attic are extremely loath to submit to any operative interference suggested for the cure of the discharge. The parts of the ossicles which are destroyed in attic suppuration are the whole, or parts, of the head of the malleus, the body of the incus, and its short process. Or the joint between the malleus and incus may be disorganized, with destruction of the articular cartilages. Chronic suppuration of the attic is extremely intractable. This is due to



FIG. 35.—PROFESSOR HARTMANN'S ATTIC CANNULA WITH BALL SYRINGE ATTACHED.

the size of the opening, and to the fact that, although it is apparently in the most dependent part, yet pus may be lodged in various membranous compartments within, from which free drainage is impossible. The disease does not often spread downwards into the cavum tympani, as all the interstices through which pus would have passed are closed by the chronic inflammatory condition of the mucous membrane.

Pathological perforations of Shrapnell's membrane require

to be distinguished from anatomical deficiencies. These latter have no significance, being merely errors of development. The pathological perforation is distinguishable by the redness of the surrounding tissues and the presence of detritus or pus in, or the passage of pus through the opening.

TREATMENT.—The nozzle of a Hartmann's cannula should be introduced into the perforation with the aid of reflected light, and the cavity of the attic thoroughly washed out with an antiseptic solution, lysol, carbolic acid 2 per cent. solution, boric acid solution, or weak corrosive sublimate being all equally efficacious. The treatment must be carried out carefully for many weeks, and the lotions changed fairly often. If no diminution in the discharge occurs, operative procedures should be undertaken. These may be (1) an enlargement of the opening by cutting away the anterior attic wall with Krause's forceps (Fig. 43); (2) ossiculectomy; (3) the radical mastoid operation. The choice of these procedures will vary according to the experience of the operator.

As alternative treatment the surgeon may wash through the ear and attic from the Eustachian tube, using either normal saline solution, employing for this purpose a syringe and Eustachian catheter, or the izal oil treatment recommended on p. 98 may be tried.

COMPLICATIONS.—Vertigo, nystagmus, sickness, pain, headache, tinnitus, granulations and polypus, cholesteatoma, necrosis of the ossicles, necrosis of the temporal bone, necrosis of the labyrinth, external and internal fistulae, contraction of the meatus, facial paralysis, lateral sinus pyæmia, extradural abscess, meningitis, cerebral abscess, cerebellar abscess.

Vertigo on Syringing, and Lateral Nystagmus.—When a patient complains of vertigo on syringing the ear the practitioner should make inquiries as to whether the objects in the room have a tendency to gyrate in the same

direction, or if the patient has a tendency to fall in any particular direction. To obtain definite information upon the vertiginous complication, it is necessary that the practitioner himself should syringe the ear; the solution, to make the test more reliable, should be a little colder or warmer than usual. If the disturbance of equilibrium is general, it may be attributed to pressure on the footplate of the stapes; if, on the contrary, the objects have a tendency to rotate in the horizontal plane, or if the patient tends to fall towards the side which is being syringed, the lesion is probably in the region of the external semicircular canal. This is corroborated if lateral nystagmus can be elicited, the oscillations in this case being extremely small and transitory in character as compared with those found in meningitis and cerebellar abscess; at times the vibratory movement is evident in an acute exacerbation of a chronic otorrhoea. These effects are caused either by an erosion of the bony semicircular canal and the consequent exposure of the membranous canal to the hot or cold lotion; or when nystagmus is present alone and is not elicited by syringing, it is due to an ostitis extending inwards from the iter or aditus, which compresses somewhat the canal.

Granulation Tissue and Polypus.—Aural polypi are composed in every instance of ordinary, or, later, of organized granulation tissue, and arise either from ulcers of the mucosa or are exuberant granulations springing from diseased bone. The presence of polypus in the ear may commonly be assumed if the discharge is at times tinged with blood. They are not infrequently cast off spontaneously, a cure probably due to a twisting of the pedicle or to its degeneration. They may be removed during syringing, more especially when an indiarubber tube is used, and its end has been introduced beyond the growth. Polypi occasionally cause a series of symptoms quite peculiar to themselves; in these cases, touching the polypus

may alone give rise to the most severe vertigo, ending in unconsciousness, whilst nystagmus and sickness are sometimes the result of any application. At other times, from their size, they may obstruct the outflow of pus from the ear, and so set up a state of septic intoxication. The polypus must be distinguished from a red and bulging membrane and from the lining membrane of the tympanum, especially that which covers the promontory, when red and thickened and of a granular appearance ; it also requires to



FIG. 36.—AURAL POLYPUS PROTRUDING FROM MEATUS.

be distinguished in rare instances from a red and smooth foreign body. A polypus, when entirely within the ear, can be distinguished from a bulging membrane by the fact that the latter is an acute condition, whereas a polypus is comparatively rarely found in an acute otitis media, and in the fact that a polypus can be freely moved about by a probe, and by the passage of the probe all round it; further, if it is soft, it usually bleeds very freely, and when pressed upon does not give a sense of resistance, as does the

promontory. If it is a foreign body, it will usually be hard. Polypi at times project beyond the orifice of the external meatus, growing to a large size. This condition is becoming much rarer in civilized countries on account of the greater appreciation of the gravity of discharge from the ear. Small polypoid growths projecting through Shrapnell's membrane appear as small red masses hanging down above the handle. They occasionally arise at the edge of a fistula in the canal, and then will be found attached to the wall of the meatus when an attempt is made to pass the probe round them.

PATHOLOGY AND HISTOLOGY.—An aural polypus has its origin in a button of granulation tissue, which is almost invariably the outcome of suppurative inflammation. It is, in fact, the 'proud flesh' of our predecessors. The button of granulation tissue takes on exuberant growth; blood-vessels develop within it; its surface becomes gradually clothed with a layer of epithelium, generally squamous, sometimes tending towards the columnar type, especially if the polypus becomes branched and its surface irregular. The future changes which take place are materially influenced by the period occupied by its growth. The first alteration in the histological structure after the development of the bloodvessels is the conversion of the whole mass by gradual stages into a soft fibroma, the white blood-cells becoming spindle-shaped cells. A secondary contraction of the older tissues now takes place, and a firmer fibrous structure is attained, which gradually proceeds until the whole polypus is a small pedunculated fibroma. Should the blood-supply of the polypus be free, the growth may either remain a fibroma or take on the characters of an angio-fibroma by excessive development of its bloodvessels. If, on the other hand, the bloodvessels are insufficient to supply nourishment to the mass, mucoid degeneration takes place, the fibrous tissue apparently becoming resolved by mucoid

degeneration, while the connective-tissue elements form the beautiful branching stellate cells characteristic of the myxoma, and the growth is now either a myxo-fibroma or a pure myxoma.

TREATMENT OF AURAL POLYPI.—The treatment of aural polypi must not interfere with the treatment of the disease of which they are a complication. If the polypi are small and really not more than slightly exuberant granulations, no operative measures are usually necessary. If, however, they are of appreciable size, the sooner such growths are destroyed the better.

No operation for the removal of aural polypi should be commenced until careful antiseptic precautions have been taken. If this be done no ill-effects will accrue. A thorough antiseptic irrigation at the time of operation will be sufficient, but a previous cleansing and packing of the canal with antiseptic gauze is much to be desired, should time and opportunity permit. Polypi may be removed in a large number of cases under cocaine analgesia ; but if the patient is nervous, or if touching the polypi gives rise to unpleasant symptoms, resort should be had to general anæsthesia.

In most cases the destruction of the polypi is accomplished either by means of a small snare, or by a curette, though the valuable and curative powers of caustics and astringents must not be forgotten.

If the snare is used, the most convenient instrument is Grüber's. It is threaded with fine wire, and the loop is regulated according to the size of the speculum used ; it can most conveniently be gauged by tightening the wire round the tip of the speculum next smaller in size. The loop is now bent at almost right angles to the shaft of the snare, and gently introduced round the polypus, as deeply into the meatus as possible. The snare is slowly tightened, and it is better not to cut entirely through the polypus, but rather when a firm hold is obtained, to pull off the growth by

sharp tug, thus making sure of obtaining the whole of it. Bleeding is sometimes free, but can be controlled by plugging with gauze after the meatus has been well syringed out with a strong antiseptic solution, as 5 per cent. carbolic acid or 1 in 3,000 hyd. perchlor.

When no haemorrhage occurs, or after it has been checked, the stump of the growth should be touched with tinct. ferri perchlor., or some similar astringent.

Polypi may also be removed by means of a blunt curette. If the curette is used, it should be passed to the base of the growth, within the tympanum, if that is the place of origin, or if the meatal wall be the site of growth, then the curette must be kept as closely applied to the meatus as is possible. The pedicle, or base of the growth, is to be pressed firmly against the meatal wall, and divided by sharply withdrawing the instrument, keeping the curette firmly against the meatus. This is certainly the more rapid method, and is also the more easily used and the more efficacious when performed under general anaesthesia, but without it is slightly more painful than removal by snare.

After the growth has been cleared away and bleeding arrested, the site from which the polypus sprang, together with any smaller polypi which may have been brought to light, and are too small for removal, should be touched with chromic acid fused on the end of a probe, or trichloracetic acid.

If the patient refuse to submit to any operation, the polypus may be destroyed by means of chromic acid, a slow and somewhat tedious process, except in the case of small growths. This method of destroying polypoid growths, as practised by Politzer, consists in the application of a single crystal of chromic acid to the polypus. The crystal, if the growth be small, will sometimes cause a complete sphacelus of it. If this favourable result does not happen, when the slough separates the process is repeated until complete

destruction is obtained. It is always well to remember that in soft and pedunculated polypi a vigorous use of the syringe will not infrequently rupture the connection of the growth. A very effective method of destroying granulation tissue and smaller growths is the use of alcohol. Any one of the lotions in the appendix may be employed in the form of drops; 10 to 20 minims should be poured into a previously warmed teaspoon, and then allowed to flow into the affected ear, whilst the head is inclined to the opposite shoulder. These drops should be allowed to remain in the ear for about twenty minutes, repeating the treatment three or four times daily after syringing and drying the meatus.

Cholesteatoma.—**PATHOLOGY.**—Cholesteatoma is an exaggeration of the normal desquamation constantly proceeding from all epithelial surfaces. The mucous membrane of the middle ear having at first become somewhat epidermized, the dead epithelial cells which should be cast off are retained in their place by the presence of retained secretion or by some other form of obstruction; excentric pressure is thus gradually exerted by this inert and constantly increasing mass, which in course of time obliterates the papilla normally found in the rete, and reduces the whole epidermized mucous surface to a membrane of extreme tenuity and one having a perverted function. This pathological process invariably commences in the upper part of the tympanic cavity—that is to say, in the attic—but it may extend over the whole of the internal wall of the tympanum and will persist after the removal of all obstruction; the extension may proceed to such an extent that it involves besides the attic, the whole of the antrum, and may penetrate one of the fossæ of the skull, as well as hollow out the whole of the mastoid process itself; the bones are absorbed in consequence of the pressure as an effect of the process. The cholesteatomatous formation does not invade osseous tissue after the manner of a malignant tumour.

Cholesteatoma almost invariably occurs as the result of chronic suppuration in the middle ear, though some observers maintain that it may be primary. Cases certainly do exist in which a small cholesteatomatous mass is observed beneath an intact membrana tympani, but usually a history of former suppuration can be obtained, and a belief in original cholesteatomatous formation without previous or existing suppuration in the middle ear is not by any means universally held. Under the microscope the tumour consists of laminated layers of epithelium, amongst which cholesterol crystals are to be found.

The objective appearances of this condition consist, in the severer cases, of a yellowish adherent mass within the tympanum, extending at times to the deeper parts of the external meatus; the material, when removed by the syringe or forceps, is found to consist of dead epithelium, more or less discoloured, the lower layers being extremely adherent to the underlying tissues, though in some cases all except the most recently-formed layer come away very easily. In the less advanced cases the inner wall of the tympanum, instead of being of a pink or yellowish colour, is white and rough, and attempts to remove this adherent material cause pain, and are often attended by slight bleeding.

TREATMENT.—This depends entirely upon the extent of the disease, for if extensive, and there is reason to suspect that the antrum is involved, it will be necessary that this cavity should be opened in order to treat the morbid changes effectively, and without unnecessary delay. In cases which present smaller areas of disease, all the flakes of tissue should be removed by means of the curette or syringe; under such circumstances an antiseptic solution should be invariably used for irrigation. It is often necessary to use solvents to loosen and dissolve the epithelium for some time before it is possible to clear away completely

all the dead and diseased tissue. Unless the patient is under close observation there is a distinct objection to the use of aqueous solutions in the treatment of this disease, whether in attempting to remove the mass or to soften it, for cases are on record in which fatal results have followed. The reason of this is that the cholesteatomatous mass imbibes water freely, and in consequence swells. Since the mass contains a large number of micro-organisms, they are thus forced into the surrounding tissues, and septic absorption follows. Of all the solvents salicylic acid is the most

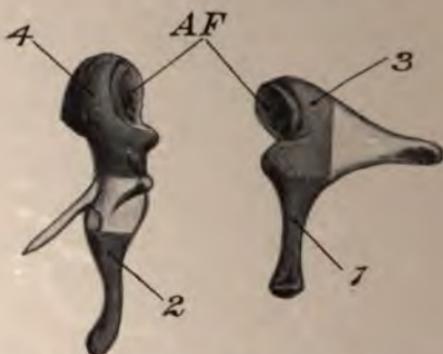


FIG. 37.—DIAGRAM SHOWING THE TWO LARGER OSSICLES SHADED TO SHOW THE MORE USUAL SITES OF CARIOSIS.

1 and 2, The most common; 3 and 4, the next, the lightly shaded parts resisting the longest; *AF*, articular facets.

useful, and it may be used either as a solution or as a paste (see Appendix 19 and 40); whilst for purpose of irrigation weak solutions of formalin or perchloride of mercury form the best fluids; the preliminary use of peroxide of hydrogen is often extremely valuable. This preparation, of the strength of 10 to 20 volumes, may also be used with great efficacy after a solvent has been used for a week or so. It will then bring away large quantities of material, or loosen them sufficiently to allow of their removal by syringe.

Necrosis of the Ossicles.—The significance of this

condition is dealt with on p. 141. The following perforations of the membrane are those more usually associated with this complication: Perforation in Shrapnell's membrane, and in the posterior superior quadrant, and cases of complete or extensive destruction of the drum. In order to detect a necrosed ossicle, use is made of the end of a fine probe bent at an angle of 120° , the upturned portion being about $\frac{3}{16}$ inch in length. The most suitable probe for this examination is Hartmann's. This instrument is introduced through the perforation in the direction of the head of the malleus, and if necrosis is present a fine grating will be felt by the examiner and heard by the patient.



FIG. 38.—NECROSIS OF THE LABYRINTH.

a, Cochlea; b, one semicircular canal; c and d, vestibule, internal auditory meatus, and semicircular canals. Seen from both sides.

Necrosis of the Temporal Bone.—This complication is more frequent in children, and is of infinitely greater rarity than necrosis of the ossicles. Necrosed pieces of bone of any size, usually black on the surface, may partly or entirely occlude the external meatus. They are readily detected by the probe, and may consist of a portion of any part of the temporal bone, and vary in size from thin flakes to large irregular masses; in a fair number of instances, and these commonly in adults, a sequestrum has been found of part or the whole of the osseous labyrinth (Fig. 38).

Necrosis of the temporal bone demands more prompt removal than does necrosed bone in most other parts of the body, and it is usually removed by means of the opening

made for the radical mastoid operation. The operation is more imperative if the bone lies deeply and involves the petrous portion of the temporal bone, for the important relationship that the internal jugular vein and internal carotid artery bear to the labyrinth must be borne in mind. Formerly, it was advised to accomplish the removal of small flakes of dead bone by means of the instillation of



FIG. 39.—OUTER SURFACE OF TEMPORAL BONE OF A FOUR-YEAR OLD CHILD, SHOWING NECROSIS OVER THE SITE OF MASTOID ANTRUM.

N, Area of necrosis, consisting of external antral wall; *GC*, glenoid cavity; *FO*, fenestra ovalis.

dilute hydrochloric acid. This, however, is a tedious, unsatisfactory, and somewhat unsurgical procedure, and should not be resorted to unless under very exceptional circumstances.

The presence of necrosed bone in the middle ear or tympanic cavity, or elsewhere in this region, becomes immediately a proper indication for the performance of the radical operation. These sequestra should not be removed

through the external meatus, as it is not possible to be sure that in extracting them through the meatus some large and important structure may not be injured, as, for instance, the bulb of the jugular vein. The radical operation is the proper surgical procedure.

External and Internal Fistulæ.—External fistulæ are usually found close behind the auricle, and lead down to the cavity of a chronic abscess in the mastoid. Fistulæ in the external auditory meatus are found in the roof and posterior wall. Both these varieties of fistulæ are due to the rupture and subsequent discharge of an abscess situated within the mastoid, and although fistulæ are not of themselves directly dangerous to life, yet they should always be attended to, as the cavities may become infected with chronic tuberculous disease, and result in extensive areas of disease. When in the roof of the meatus they lead into those cells which have been described as the 'border cells,' lying external to the attic; whilst fistulæ in the posterior wall lead either directly into the antrum or into one of the large cells in the mastoid.

The treatment of these cases, with the exception of sinuses in the roof of the external meatus, is the radical operation. When the sinus is in the roof, with an intact membrana tympani and good hearing, a cure may at times be obtained by an energetic use of the curette without external operation, or the performance of an incomplete mastoid operation; the removal of the disease without opening the antrum may result in complete healing.

Contraction of the Meatus.—Whether this be membranous—that is to say, cicatricial—or whether it be due to bony outgrowth—exostosis or hyperostosis—it becomes imperative that a radical operation should be done within a reasonable time, especially if there be a discharge which is at all hindered in its escape by the contracted condition. The membranous stenosis of the external meatus is brought

about by an inflammatory exudation within its wall, which, when converted into fibrous tissue, results in a circular contraction of the canal. Hyperostosis, or a bony outgrowth, may be due to the irritation of the discharge, or it may be a coincidence.

Facial Paralysis.—Facial paralysis, or Bell's palsy, is a complication which may occur either in acute or chronic disease of the middle ear. So long ago as 1872 Sir William Dalby pointed out that those cases of facial paralysis said to have followed exposure to a draught were frequently due to an acute median otitis, the pain of which was so slight and evanescent as to have been quite overlooked both by patient and physician.

In acute suppuration of the middle ear, especially in children, paralysis of the face on the same side may supervene, which will get quite well after the otorrhoea has been cured, though perhaps not immediately ; in a large number of cases the use of the galvanic current will be necessary. The nerve, in those cases of paralysis which complicate acute disease of the middle ear, is compressed within the bony tube by inflammatory products, due to an extension of inflammation from the mucous membrane lining the tympanum to the neurilemma and to the periosteal lining of the Fallopian canal, by means of a perforation frequently found in the wall of the canal just at the point where the nerve passes above the foramen ovale.

A facial paralysis in chronic suppurative disease of the middle ear is a thing of vastly different import, and has a much more serious significance. It invariably indicates a necrosis of some part of the temporal bone, and not infrequently of the labyrinth ; the paralysis is an indication for the performance without delay of the radical mastoid operation, and in cases of tuberculous disease signifies an extension of the malady. It may occur as a central lesion or at any rate as a lesion not due to any interference of the

nerves in their passage through the temporal bone. In such cases there will be other indications to guide the surgeon to a correct estimate of its significance.

Erosion of the Internal Carotid Artery.

This rare complication is usually due to destructive ulceration arising in the course of chronic suppurative middle-ear disease. It has, however, occasionally been reported as having occurred in children in whom there has been no previous intimation of any disease of the ear, although it is impossible to avoid the suspicion that it was due to the before-mentioned cause. In such a case the patient will have a sudden haemorrhage from the nose, mouth and ear, which may be immediately fatal, or may prove so by a recurrence of the haemorrhage even before assistance can be obtained. Post-mortem examination shows that the ulcerative process has in its course eroded the arterial wall.

TREATMENT.—The treatment must be directed primarily to stopping the haemorrhage, and secondarily to the prevention of its recurrence. If the haemorrhage is very severe and is not controlled by pressure on the internal carotid artery, the best line of treatment consists in the ligation of this vessel and the performance of the radical mastoid operation. All carious bone is to be removed, and the cavity thoroughly cleansed with a very strong antiseptic, as advised on p. 191; a plug is used to seal up and compress the artery in its bony canal if the vessel can be reached.

Hæmorrhage from the Jugular Bulb.

When haemorrhage occurs in this situation, it may be from an ulcerative process eroding the external wall of the bulb in a similar manner to that which has just been alluded

to in the case of the internal carotid, or it may be due to the long wall of the vessel being punctured during incision of the membrana tympani. In rare instances the bony protection afforded to this portion of the jugular is absent, and the vein lies just above the mucous membrane of the posterior and interior part of the inner wall of the tympanum. In such instances the surgeon might notice a pulsatory movement conveyed to the membrana tympani, or even visible through it, and probably also a bluish reflex in the posterior inferior quadrant of the membrane. From whichever cause the haemorrhage arises, careful and deep plugging under proper antiseptic precautions will allow healing to take place in the wall of the vessel. Should the haemorrhage be due to ulceration, antiseptic irrigation, even while haemorrhage is taking place, should be employed. Here, as in the former case, rest in the recumbent position and absolute quiet are to be enjoined on the patient. In the event of failure of these measures, the sinus should be exposed and compressed with a plug, as described on p. 175, and it may even be necessary also to ligate the internal jugular vein.

Abnormal Conditions occurring as Sequelæ to Chronic Suppuration in the Middle Ear.

In the meatus, besides those conditions already described, various contractions may be found. These may take the form either of a diaphragm entirely occluding the meatus, or of a cicatricial contraction with a central perforation. In the former instance suppuration will have ceased; consequently behind this web it is rare to find retained secretion. If, however, there is a hole in the centre of the web, more frequently than not suppuration is still going on, and pus is exuded more or less copiously through the opening. If the web be complete and deafness result, a

crucial incision should be made, the knife cutting right down to the bone, or a circular incision made to remove the whole of the obstruction. A metal tube should be afterwards introduced into the meatus large enough to fit fairly tightly ; this dilator must be retained in the ear for about a month or six weeks, the passage irrigated two or three times a day with antiseptic lotion, and the tube taken out at least once a day and cleansed and replaced. The wound heals in the course of a week or ten days, but it is necessary

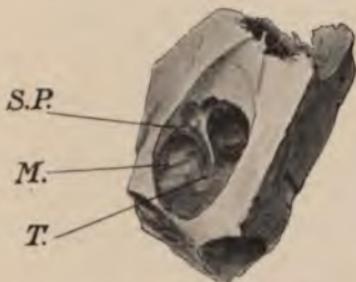


FIG. 40.—PREPARATION SHOWING THE HANDLE OF THE MALLEUS BOUND DOWN BY CICATRICIAL TISSUE AFTER CESSION OF CHRONIC SUPPURATION.

SP, Short process ; *M*, cicatricial membrane ; *T*, tip of malleolar handle adherent to promontory.

to keep the tube in the meatus for the time mentioned, in order to overcome the tendency of a second membranous web to form through cicatricial contraction. If, however, there is still discharge, showing the presence of suppuration in the middle ear, it is wiser immediately to perform a radical operation than to attempt to dilate the stricture, as this is a tedious process, and not—theoretically, at all events—devoid of risk. During the process of dilatation, if laminaria tents are used, as is commonly advised, the pus is retained as long as the tent is in position, and septic absorption is encouraged. Unless the disease in the middle ear is

entirely cured, contraction will occur again, and the patient within a short time will be in the same state as if no treatment had been adopted.

The membrana tympani itself may exhibit many post-suppurative changes. If the original perforation were extensive and have become entirely filled in, this scar membrane will be thinner than the normal, will contain far less fibrous tissue, and at the same time this fibrous tissue will not have the necessary resilience nor proper arrangement of its fibres; it will thus be easily influenced by changes in pressure either from without or within, and in consequence it often becomes extremely retracted, even to the extent of lying closely applied to the inner wall of the tympanum.

The reverse condition of this, in which, after suppuration has ceased, a large part of the membrane is found to have undergone calcareous degeneration, is not to be attributed entirely to the effect of suppuration, but partly to coincidence, as this chalky change is found with equal frequency in patients, some very young, who have never suffered from suppuration.

At other times the membrane does not exhibit signs of healing, and the perforation persists, the edges of which are usually thickened and rounded, having much the appearance in miniature of the edges of a chronic ulcer of the leg. This variety has been termed a residual perforation, and it is possible at times to obtain its healing by means of the irritation of its edges. This mode of treatment is only advisable if the perforation be small, and if a pledget of wool making good the gap improve the hearing. The slight operation should be done under mild, though careful, antiseptic precautions. If the antiseptics used are too strong, the moderate degree of inflammation which is necessary for the healing process will be checked. There are two agents which have been found useful in such cases,

namely, chromic and trichloracetic acids. If the former be chosen, it must be used on the tip of a fine probe; a few crystals of the acid are picked up by the probe, which is then heated in a spirit flame an inch from its tip. The crystals melt, and the end is uniformly coated with the acid by the simple plan of rotating the probe. After the canal has been syringed with boracic lotion and dried, the prepared probe is carefully applied to the edge of the perforation. Caution must be exercised to avoid the acid melting, and so cauterizing other parts. With trichloracetic acid it is better to take the deliquesced acid on a small cotton-wool mop, and apply it in the same way. A little iodoform may then be insufflated, and the meatus lightly packed with an antiseptic wool or gauze. At the end of a day or two the perforation should be pink, and begin to show a tendency to close; it is, however, generally necessary to stimulate the edges from time to time.

An unfortunate condition is frequently seen in which the perforation has not closed. Another variety is that in which the edge of the perforation in the membrane has become adherent to the inner wall of the tympanum. In other instances the ossicles are bound down to adjacent structures by means of cicatricial bands.

The treatment of these cases depends on the amount of deafness experienced, and on the amount of improvement derived from artificial membranes. If the deafness is troublesome and no material relief is obtained by the use of the so-called artificial drum, then minor operations should be tried.

Of these operations there is one which is a fairly recognised procedure, viz., the so-called circumcision of the stapes; it may be tried in cases where the stapes has lost its connection with the incus, and is firmly tied down into the niche of the foramen ovale by means of cicatricial tissue.

After cocaine or eucaine, or Gray's solution, has been applied and the part rendered insensitive, a spud-shaped knife or a sharp-pointed myringotome is used to divide the scar tissue by parallel lines down almost to the bottom of the foramen ovale. Material improvement of hearing will frequently follow, but the result does not usually last for more than a few weeks, when the treatment must be repeated, the surgeon endeavouring to follow in the lines of the original incisions. The operation requires to be done at least three times, and in a fair proportion of cases a degree of lasting improvement is obtained.

A modification of this line of treatment consists in applying a minute quantity of chromic acid into the fresh incisions, so as to cause a sloughing of the cicatricial tissue, and thus prevent the necessity of more than one operation. This method has a slight disadvantage, inasmuch as the Fallopian canal is sometimes deficient in this region, and the swelling set up may cause temporary facial paralysis. Other divisions of cicatricial tissue must necessarily depend upon the situation of the bands, and at times it is justifiable to perform a complete ossiculectomy with the hope of improving the condition of deafness.

When the perforation is in the upper part of the membrane, and the edge of the meatus somewhat destroyed by the suppurative process, especially if the attic is involved, a condition almost approaching cholesteatomatous formation is observed—that is to say, adherent flakes of skin are found which have formed in this situation, and are not thrown off. They can be easily removed by the aid of fine forceps after having been loosened by the use of a probe; their removal will frequently very considerably improve the comfort of the patient, and also perhaps his hearing power.

CHAPTER VIII

INTRACRANIAL COMPLICATIONS

Meningitis.—Infection of the meninges of the brain may occur in the course of otitis media suppurativa, either in acute cases, with perforation of the tympanic membrane; as a sequel to acute mastoiditis, without perforation of the drum; or in chronic suppuration of the middle ear. Infection is usually direct, and in a considerable number of cases there is an extradural collection of pus, and meningitis may co-exist with any of the other septic intracranial complications.

SYMPTOMS.—The patient complains of feverishness and cephalalgia, ushered in at times by a slight rigor, with vomiting, and he has at this time a quick and full pulse. With the progress of the disease the cephalalgia becomes more intense, and, in common with the other otitic intracranial complications, becomes so severe that the patient cries out with pain. Intolerance of light, at times amounting to photophobia, with hyperæsthesia acustica, together with marked retraction of the head in basic infection, become marked. The pupils, which are commonly unequal, react to light, but usually more or less slowly than normal. Optic neuritis, or papillitis, will in most cases be noted. The patient now tends gradually towards a lethargic state of mind and body. The pupils become widely, though often unequally dilated, and all reaction to light gradually is

lost; whilst in basic cases a tendency to squinting is more frequently noted than in other varieties. A partial paralysis, or hemiplegic condition, may set in at this stage of the disease, but eventually total paralysis, with stertor and profound insensibility, will occur if the effusion is great. The pulse-rate during the latter part of the illness is rapid and irregular; the respirations are also irregular, though slow. Nystagmus may be present in the later stages of the disease.

TREATMENT.—When the patient is seen at the commencement of the affection, immediate operation offers the best hope of saving life. The meninges are freely exposed by an extension of the radical mastoid operation and incised, the immediate area of disease bathed with boracic lotion and dressed with antiseptics. A culture from the infected area should be taken, and if this proves the presence of streptococci, the effect of the antitoxin may be tried. The most hope from drugs comes from a careful and judicious use of mercury and bark, combined with opium for the relief of pain, or large doses of calomel and quinine; ice-bags to the head should be employed, and the patient kept strictly quiet in a darkened room.

Extradural Abscess.—An extradural abscess of aural origin is the result of an extension of suppurative processes in the middle ear and the antrum. This extension may take place either through the roof of the attic by perforation of the tegmen tympani, or by the passage of pus through the channels in the bone, the abscess is situated external to the dura of the middle fossa; but if the infection proceeds through the antrum and the cells connected with it, the purulent collection will lie in the sigmoid groove between the bone and the lateral sinus. The extradural collection of pus found in the middle fossa is almost invariably the product of chronic suppuration; whereas the abscess situated in the sigmoid sinus may be found as a result either of acute or chronic suppuration.

SYMPTOMS.—The only constant symptom in extradural abscess is cephalgia. This is often so intense that the patient rolls in agony or cries out with pain, and is unable to sleep at night. This severity of suffering is more especially the case when the abscess is the result of chronic suppuration of the middle ear. Percussion over the squamous portion of the temporal bone or deep pressure will usually locate a small painful area, at which point the pain is most noticeable, and from which it radiates. The pain is of a neuralgic character, spreading upwards over the side of the head. The temperature is usually but slightly raised above the normal. The pulse may be either unnaturally slow, normal, or slightly accelerated, and, if the extradural abscess is uncomplicated, it is rare to find optic papillitis. Thus reliance has largely to be placed upon the history of the case, which may be that of an old-standing suppuration from the ear, with gradually increasing cephalgia; at the commencement the pain is little more than a severe headache, but, as noted above, it may become sufficiently severe to prevent sleep and cause the greatest distress to the patient. If the abscess becomes of large size, there may be symptoms of cortical irritation, as evinced by spasms of the muscles of the limbs on the opposite side of the body, and in rare cases the patient may become comatose. The acute cases are those following influenza, in which the mastoid consists entirely of cells. In such cases the pain will have been severe, and the whole mastoid process tender on pressure. If this condition is not recognised and suitably treated by operation, either lateral sinus pyæmia or septic meningitis will ensue.

TREATMENT.—Operation alone affords relief to the patient. In this, the mildest of all the intracranial complications due to suppuration in the middle ear, treatment varies with the acuteness or chronicity of the attack. In acute cases the mastoid antrum should be first opened, it is always advisable

to work from the antrum towards the abscess, following up the track by which the infection proceeded. In chronic cases an examination should be made in every instance both of the middle fossa and the sigmoid groove. Should the dura mater or the lateral sinus appear unhealthy when exposed, further examination of these parts should be made, as described under the separate diseases. Having evacuated the abscess, the cavity should be cleansed with a strong antiseptic solution, such as Lister's strong fluid, and the wound, having been well dusted with iodoform, is plugged from the bottom. In chronic cases where the radical mastoid operation has been performed, the end of the plug may be drawn through the external meatus; but even in these cases it is better not to close the wound entirely. In acute cases, where the radical operation has not been performed, the wound is not entirely closed, and the end of the gauze strip is brought out into the lower part. The evacuation of the pus is followed by an incision of the tympanic membrane, for this measure is usually necessary. The whole of the wound is now carefully irrigated, and the external meatus plugged from the bottom.

Otitic Cerebral Abscess.—Cerebral abscess occurs in the majority of instances as a sequel to, or complication of, chronic purulent otitis media. Acute suppurative otitis media is occasionally the source of infection. Cerebral abscess has been known to follow attacks of acute otitis media in which no perforation of the tympanic membrane has been observed, but in which abscess or inflammation of the mastoid antrum or one of its cells has occurred.

The following description of a cerebral abscess situated in the temporo-sphenoidal lobe may be considered as typical, but it must be borne in mind that one, or even most, of the more characteristic signs may be — indeed, often are — absent. Also, when the patient is first seen, either in the late secondary or third stage, it is chiefly by a process

of deduction and of exclusion that it is possible to arrive at a correct diagnosis.

Abscess of the brain may be divided clinically into three stages. In the first stage the patient is, in the majority of instances, a sufferer from chronic otitis media; he becomes suddenly ill, and a history of a recent chill or injury to the head may not infrequently be obtained. In this, the earliest stage, the symptoms are chiefly referred to the ear. Pain is the prominent symptom, and is of a hot, burning, or shooting character, spreading, after a short interval, over the temporal region, where it often becomes chiefly located, and then apt to become most violent in character, even causing the most intense agony. It may be either persistent or intermittent, but often so severe that the patient is almost unable to bear it. Vomiting, not referable to the ingestion of food, is likely to occur at this stage, and either before or at the same time as the onset of vomiting a slight rigor is usually noticed, with a moderate rise of temperature. This probably does not exceed 103° F., and in uncomplicated cases is rarely repeated. The general state of the temperature during this, the first stage, is only slightly above normal, whilst the pulse is quickened and the tongue becomes furred. The patient is obviously very ill, and at the time that the rigor occurs the discharge from the ear, in the great majority of instances, is lessened in quantity or ceases entirely. This stage is of variable duration, and may exist for a few hours or several days. It is, however, rarely that the patient is brought under observation at this time, as not infrequently he has suffered and recovered previously from a condition very similar, though of a less severe type, which was probably due to septic poisoning from absorption of the products of suppuration.

The second stage is that in which the patient is commonly seen. By this time the pain has become considerably

mitigated, and the state of the patient tends more towards a dull and quiet state of mind and body, so that he is apt to lie quietly dozing, except during intervals of pain. Pain at this time is not loudly complained of, but may be elicited by percussion over the temporal bone, and the head may be tender on pressure over the same area. Cerebration is delayed, and though at the beginning of the second stage questions will be answered correctly, but after a distinct interval, yet, as the abscess increases in size or as the symptoms become intensified, a distinct loss of memory will often be observed; this loss being first noticed in the inability on the part of the patient to remember the names of places with which he is perfectly familiar. He will be unable to state where he lives or to give the correct names of common articles, and there is little evidence of spontaneous cerebration. The inclination to sleep becomes greater, and at the same time the sleep is troubled, restless, and broken. The temperature varies in this stage from 97° to 99° F., being more frequently slightly below than above normal. The pulse-rate sinks gradually to a rate varying from 30 to 60 per minute, and together with the sinking of the pulse-rate a diminution in the number of respirations per minute will be noted, these not infrequently falling as low as 11 or 12, though in cerebral abscess this slowness of respiration does not equal that observed in cases of cerebellar abscess. The bowels are usually obstinately constipated, and there is a loss of control over the bladder, which is evinced either by retention or incontinence of urine, and albumin is usually present in small quantities. Vomiting and giddiness are present when the patient is able to move about. Paralysis, when it occurs, aids materially in localizing the site of the abscess. Thus paralysis, when observed on the side of the body opposite to the seat of the lesion, may be either of the cortical or internal capsular variety. In the former instance the paralysis occurs in the

following order: First, the facial muscles, then those of the arm, and, lastly, those of the leg; but the latter are only slightly affected and sensation is preserved; while in paralysis due to pressure on the internal capsule the order is inverted, being leg, arm, then face, together with loss of sensation. When the facial nerve is paralyzed from the presence of an abscess of the brain the loss of power is not so intense as that which occurs from a lesion to the nerve in the Fallopian canal. The state of the pupil on the affected side varies. It is frequently contracted, and only reacts sluggishly to light and accommodation, in which case the abscess will be relatively small. But if the abscess is of large size, the pupil on the same side will be both dilated and stable. Paralysis of the third nerve on the same side as the abscess is a variable sign; optic neuritis, or papillitis, is found during the whole of this stage, and may be only on the affected side. The tongue becomes furred, and towards the end of the second stage sordes are frequently present on the lips and teeth, while a strong putrid odour emanates from the patient's breath, and where consciousness is preserved a subjective bad odour may be complained of.

The possible terminations of cerebral abscess after the end of the second stage are either spontaneous evacuation, or, when the disease is untreated, the patient passes into the third and final stage. Spontaneous evacuation occasionally occurs by discharge of the abscess through the external meatus, the pus having found its way through the cerebral tissues, and through a lesion in both the dura mater and tegmen tympani. This is a rare result, but one which has been from time to time reported.

In the third stage proper the patient lies in a deep comatose condition, in which Cheyne - Stokes respiration is common. This condition after the lapse of a short period terminates in death.

TREATMENT.—The treatment in the first stage will consist in a preliminary radical operation on the mastoid, with an exploration of the base of the middle fossa, by cutting away the tegmen tympani. As at this stage there is no formation of pus in the brain, no indication may be found to proceed further. Such an indication would be a non-pulsatory bulging of the dura mater.

In the second stage, although a radical mastoid operation must be performed in order to remove the primary focus of disease, the condition of the patient must guide the surgeon as to the desirability of performing this operation at the time at which the abscess is evacuated. Should the radical operation have been performed, the bone may be removed until the same region has been exposed as would have been exposed by the trephine being applied over a spot $1\frac{1}{2}$ inches behind and $1\frac{1}{2}$ inches above the centre of the external meatus. On exposure, the dura mater is incised and the brain explored either by means of the blade of a bistoury, Horsley's cerebral pus-searcher, or a large trocar and cannula. Should this measure fail in locating the abscess, the sterilized finger is, after incision of the brain substance, introduced gently into the cerebral tissue, and the abscess may be detected by a sensation of resistance and then evacuated. After pus has been found, the instrument should on no account be withdrawn unless a director is left with its point well within the abscess cavity. A double drainage tube, as large a size as possible, should be passed into the abscess cavity, which is then irrigated with boracic solution. These tubes should be secured by sutures and the wound dressed. After the evacuation of pus, the pulse will become accelerated, respiration will again become normal, while the temperature will rise, to fall, if the case progresses favourably, within a few hours. As soon as the pus has ceased discharging from the abscess walls the tubes should be

shortened and eventually removed, and the scalp wound closed by freshening and suturing its edges.

Cerebellar Abscess.—The chief symptoms pointing to the presence of an abscess in the cerebellum are frequent vomiting, severe occipital headache, want of muscular co-ordination, and giddiness.

In the earliest stage of this complication, vomiting, want of co-ordination, and giddiness are accompanied by a general feeling of illness on the part of the patient. Speaking generally, the difficulty of localizing a cerebellar abscess is greater than that of localizing a cerebral abscess. In the second stage, however, there is frequently paresis of the arm on the same side as the lesion, together with weakness of the leg, increased knee-jerk on the same side as the lesion, not infrequently conjugate deviation of the eyes to the side opposite to the lesion, along with optic neuritis. Convulsions, frequently repeated, on the same side as the lesion are an occasional symptom; while lateral nystagmus, with large excursions, is especially frequent when the abscess is situated in the lateral lobe of the cerebellum, the movements of the eyeball being towards the side on which the abscess is situated. Rotatory nystagmus points to involvement of the middle lobe. If the patient is able to move about, there may be a tendency to fall towards the side opposite to that of the lesion. The attitude of the patient in bed is characteristic of the effect of cerebral irritation—that is to say, he tends to lie coiled up, with body and limbs flexed.

TREATMENT.—The mastoid should be examined either at the same time as the abscess is sought for or later. With the special object of exploring the cerebellum, a curved incision, with the convexity upwards and commencing close behind the pinna, is carried backwards and downwards to about $1\frac{1}{2}$ to 2 inches behind the mastoid process right down to the bone; the occipital artery is usually divided, and all

the tissues, including some of the sterno-mastoid muscle, reflected so that a trephine can be applied to the skull in such a way that it lies against the posterior border of the mastoid process, with its upper edge below Reid's base line. After the disc of bone has been removed and the dura mater opened, the instrument used as a pus-searcher should be pushed firstly forwards, upwards, and inwards towards the surface of the petrous bone. If pus is not found in this direction, and as it may lie more than 2 inches from the surface, the finger should be introduced and the cerebellum explored, especially towards the tentorium, where the abscess may be situated between the upper surface of the cerebellum and this structure. When the abscess is found and evacuated, the same line of conduct must be observed as was recommended in dealing with cerebral abscess; but it is well to remember that a second cerebellar abscess is occasionally present, so that, if the symptoms are not relieved after evacuation of the first, further exploration should be immediately undertaken.

Thrombosis of the Lateral Sinus and Lateral Sinus Pyæmia.—The lateral sinus may become infected either by means of an extension of a septic thrombosis into its cavity or through one of the radicals that empty themselves into it, notably the superior petrosal sinus. The sinus itself may be primarily involved by a phlebitis either by direct infection due to extension of inflammation to the bulb, or in consequence of the extension of suppurative disease into the sigmoid groove. Thrombosis of the lateral sinus itself, so long as the thrombosis is not septic, will be attended by no marked symptoms beyond those of slight pain and slight elevation of temperature. This absence of special symptoms is largely due to the fact that the thrombosis is always accompanied by some pathological state, such as extradural abscess or inflammation of the mastoid conditions, which mask symptoms that would other-

wise make themselves obvious. When the clot has become infected by pathogenic organisms penetrating its substance, the symptoms will develop rapidly from the moment that any septic matter finds its way into the blood-stream, however minute the amount of the poison may be. Thus the symptoms of lateral sinus pyæmia will be, in its short preliminary stage, those of general illness, with an elevation of temperature and pain in the head, extending perhaps down the side of the neck. These symptoms will be followed by a rigor, attended by a rise of temperature rarely less than 104.5° , though it may not exceed 103.5° F.; the latter degree is usually the highest temperature accompanying a rigor due to the formation of a brain abscess. At this time the discharge from the ear will be lessened, or will temporarily cease. As the clot in the sinus increases in length and travels downwards, the patient, who already suffers from cephalgia, will now complain of pain and stiffness in the region of the sterno-mastoid muscle, and a careful palpation in the course of the carotid vessels will demonstrate pain and tenderness in this region; frequently the existence of a hard cord-like mass passing down towards the sterno-clavicular joint may be detected. This is caused by the presence of clot in the internal jugular vein. œdema over the mastoid process is present in a certain number of cases, and is due to a thrombosis of the emissary vein of Santorini, which is frequently found in this situation. Vomiting will usually be a marked feature of the case.

In the preliminary stages constipation is the rule, but as the case progresses diarrhoea usually develops, often accompanied by severe abdominal disturbance, a fact which may tend to throw the practitioner off his guard, and cause him to suspect typhoid fever. The rose spots of typhoid, however, will never be noticed. Increase of headache, especially if the pain extends towards the occiput, may be taken as an indication of the extension of the clot towards

the torcular Herophili. The rigors will be repeated frequently, and are usually followed by profuse perspiration, and all the symptoms commonly found in the so-called typhoid condition become gradually manifest. The skin is dry; the pulse frequent, small, and thready; sordes form on the lips and teeth; the belly is retracted; the breath has a sweet but offensive odour, and colliquative diarrhoea is the rule. Infarcts will often occur in the lungs, which are ushered in by pain resembling that of pleurisy, and cause a troublesome cough. Lateral sinus pyæmia of this type may give rise to the suspicion that the patient is suffering from the hypostatic pneumonia of typhoid, but a careful examination will demonstrate that the disease is purely local; after a short period the expectoration of prune-juice sputum will show that the chest symptoms are due to a local septic pneumonia. Infarcts also incur in the various joints, especially the smaller ones, and in other parts of the body.

The main points of diagnosis between typhoid fever and lateral sinus pyæmia are the absence of the rose-coloured spots of typhoid in this disease, the absence of pain in the right iliac fossa, the characteristic temperature chart of pyæmia, which differs markedly from that of enteric, together with the history of discharge from the ear. Widal's reaction is negative in pyæmia.

TREATMENT.—Of all intracranial complications of suppurative otitis media, this is the one which needs the most prompt and efficient relief. As soon as the diagnosis is made that the patient is suffering from lateral sinus pyæmia, an operation should be immediately undertaken. It consists primarily in exposing the sinus in the sigmoid sulcus, which should be accomplished by continuing backwards the bony wound formed after having done a rapid radical operation on the mastoid antrum. As soon as the sinus is reached, it should be exposed for at least an inch,

and the vessel carefully examined with the finger, and if it is felt hard and clotted, an incision is made in its wall, and the clot removed by curetting first in one direction and then in the other, until the blood flows with a free stream. This hæmorrhage is checked by the insertion of a strip of gauze, which is packed in tightly between the sinus wall and the skull. The infected channel must be carefully cleansed with antiseptics, and the wound similarly dressed. If, however, the clot extends into the jugular vein, or if the operator is unable to obtain a free flow of blood from the cardiac end, the jugular vein must be exposed in the neck by means of a long incision down the anterior border of the sterno-mastoid muscle, and the vein ligatured, if possible, below the clot. The vein is then divided, the clot removed, and an attempt made to syringe through from the vein into the wound in the skull. If the operator is unable to accomplish so much, it would be better to dissect out the whole of the vein, including the jugular bulb, and although this extension of the operation is an undertaking which is of considerable magnitude and difficulty, yet it is undoubtedly the correct surgical procedure.

CHAPTER IX

OPERATIONS

I. Minor Operations.

OPERATIVE measures undertaken for the relief of deafness and tinnitus have one general principle—the division of the structures which interfere with the normal mobility of the ossicular chain; such examples are the division of the tendon of the tensor tympani, division of the posterior fold or ligament of the malleus, the division of the anterior ligament of the malleus and of the tendon of the stapedius, as well as the separation of other adhesions. With the exception of the latter, these minor operations are described in Chapter VII., and obviously no definite instructions can be laid down for the division of adhesions. Every adhesion which appears to have a probable influence upon the hearing should be divided, more especially those attaching the drum to the long process of the incus, which must be carefully dissected off with a myringotome curved on the flat; the frequent use of inflation besides rarefaction of air in the external meatus is to be employed to prevent readhesion during healing. These small operations are more beneficial when undertaken for the relief of tinnitus than for the improvement of audition, and patients should not be led to expect much betterment of their hearing.

Paracentesis, or Incision of the Drum.—The external meatus must be irrigated with an antiseptic solution

and carefully dried. If a general anæsthetic is used, the light may be carefully focussed on the ear before the patient is deeply unconscious, in order to avoid undue waste of time, and especially so if nitrous oxide is used. The only instrument required is a sharp-pointed myringotome. The drum is perforated posterior to the handle of the malleus, within a short distance of the posterior fold of the membrane. The inner tympanic wall should not be touched. The knife is then passed straight down to the inferior part of the membrane, dividing it in almost its whole length. The external meatus is then washed out with a 5 per cent.



FIG. 41.—MYRINGOTOMES, SHARP AND BLUNT POINTED.

solution of carbolic acid, and a strip of sterilized gauze used to plug the canal.

Division of the Tendon of the Tensor Tympani.—This operation may be performed under cocaine anæsthesia, but it is preferable to use a general anæsthetic. If cocaine be chosen the aniline preparations must be employed, and strict antiseptic precautions are to be observed. An incision is made behind the handle of the malleus, commencing at the level of the short process, and extending down half the length of the handle. A tenotome is now introduced, either above or below the tendon, which is severed by a sawing movement of the knife. After the tenotome is removed a curved probe should be inserted in order to ascertain that the division is complete. Healing of the wound in the tympanic membrane will take place under antiseptic precautions in a few days, at the end of which time inflation should be employed in order to obtain

improvement in hearing. The handle of the malleus tends to resume its normal position after this operation. In those cases in which the malleus is extremely retracted it may be necessary to divide the tendon through an interior incision, there not being sufficient space for a posterior incision.

The hæmorrhage from this slight operation is rarely troublesome, and may be easily checked by plugging.

Division of the Posterior Fold of the Membrane.—This procedure should only be employed when the structure is prominent and tinnitus is very severe. It must be divided from below with a sharp-pointed tenotome.

Division of the Anterior Ligament of the Malleus.—A sharp-pointed myringotome is inserted just below and in front of the short process. The knife is then forced upwards with a sawing movement towards the notch of Rivini, when the ligament will be felt to divide beneath the knife.

Division of the Stapedius Tendon.—The field of operation must be exposed by cutting a flap in the membra tympani which will fold downwards. This may be done by inserting the knife behind the handle of the malleus on a level with its short process, dividing the membrane horizontally backwards to the periphery, and then turning and cutting downwards for nearly the same distance. The slight bleeding which ensues must be checked by gentle pressure. When the hæmorrhage has been controlled, and after the removal of any blood-clot which obscures the field of view, the tendon is seen passing horizontally backwards from the head of the stapes, like a fine white thread. It is divided, the parts thoroughly cleansed with antiseptics, and the wound gently plugged. The wound in the membrane will heal with great rapidity.

Certain minor operations are described in the text—viz.,

paracentesis for the removal of mucus, circumcision of the stapes, and the removal of polypi.

II. In Suppurative Otitis.

Ossiculectomy, including the Removal of the Remains of the Ossicles, Drum, and External Attic Wall.—The operation of ossiculectomy originally consisted in the removal of the remains of the drum-head and of the larger ossicles only. It is now made to include, in addition, the removal of as much of the external attic wall as can be cut away and removed through the external meatus.



FIG. 42.—INCUS CURETTE.

It is an operation by which the surgeon attempts a cure without resorting to a radical operation on the mastoid in troublesome cases of prolonged chronic discharge from the middle ear; it is only to be employed where the temporal bone is not carious, and it cannot be successful unless the antrum be so situated that efficient drainage is possible. It should not, as a rule, be performed until the patient has been under treatment for chronic suppuration for at least three months. It is chiefly indicated where the patient

finds it impossible to give up his occupation for the length of time necessary in order to undergo the larger mastoid operation, since a week's rest in bed usually suffices after ossiculectomy to permit his safe return to duty, provided he remains under observation and has the wound dressed regularly.

The indications for removal of the ossicles may be taken to consist in : (1) A suppuration of more than three months' duration where ordinary treatment has failed; (2) when suppuration has ceased, and the consequent cicatrization has bound down some of the small bones of the ear by scar tissue and has rendered the patient deaf, if, in the light of known facts (see tuning-fork tests), the aural condition will be improved by operative procedures.

Preliminary Preparations.—Twenty-four hours before the time elected for operation the ear should be thoroughly cleansed by irrigation with peroxide of hydrogen of the strength of 10 volumes, after which it should be thoroughly syringed with 5 per cent. carbolic acid; the meatus is then plugged with a strip of gauze wrung out in the same solution, the gauze being left *in situ* until the time of the operation. A general anaesthetic is necessary, and the operation is performed with the aid of reflected light. If the recumbent position is used, the operator must bear in mind the altered appearance that the drum will present, the malleus appearing to lie horizontally instead of vertically. After the packing is removed, the ear must be carefully dried with pledgets of sterilized cotton-wool, care being taken to avoid as far as possible any injury to the tissues, which might cause bleeding, and so obstruct the view.

Operation.—A blunt-pointed myringotome is now inserted in front of or behind the short process of the malleus, and carried in a circular direction completely round the drum at its junction with the meatus. The line of incision must be kept as close to the bone as is possible, and completed at

the opposite side of the malleus to that on which the knife was inserted. The knife is then withdrawn, and the malleus firmly seized with a pair of strong forceps—preferably Hartmann's—as far above the short process as is possible. The malleus thus gripped is then drawn downwards and outwards, thus rupturing the ligaments and tensor tympani tendon, and at the same time removing the remains of the membrana tympani. Many operators prefer removing the malleus by Delstanche's extracteur. The loop of this instrument is made to embrace the handle of the bone, and has its sharp edge upwards; this movement severs the tendon when the sharp edge strikes it, and the bone is then removed by pulling downwards and outwards. The loop of an incus hook is now inserted into the attic, so as to occupy the site previously occupied by the head of the malleus. When in this position it is rotated backwards, so that what remains of the head of the incus is embraced in the loop, and then by a forward and downward movement the incus is dislocated into the cavum tympani, and if not removed by the loop of the curette, it may be cleared away either by syringing or forceps. All bleeding is controlled either by a cotton-wool plug soaked in adrenalin solution, or by irrigation with hydrogen peroxide of the strength of 10 volumes; pressure is often all that is required. The external attic wall is now cut away either by means of a long cross-cut dental burr protected at the end or by Krause's osteotome (Fig. 43). The bone should be ablated more posteriorly and superiorly than anteriorly, and an attempt made to remove the attic wall so thoroughly that a probe bent at the tip and passed into the attic may be withdrawn without encountering any resistance. The cavum tympani must now be curetted in order to remove all granulation tissue, and freely mopped out with Lister's strong fluid (*vide Appendix*) or pure carbolic acid, or pure carbolic acid and formalin (equal parts); the first solution

is less often followed by facial paresis. The cavity is finally freely irrigated; the antrum itself washed out by means of a dental cavity syringe, and Lister's strong fluid may be used for this purpose.

The meatus is firmly plugged with a long strip of sterilized

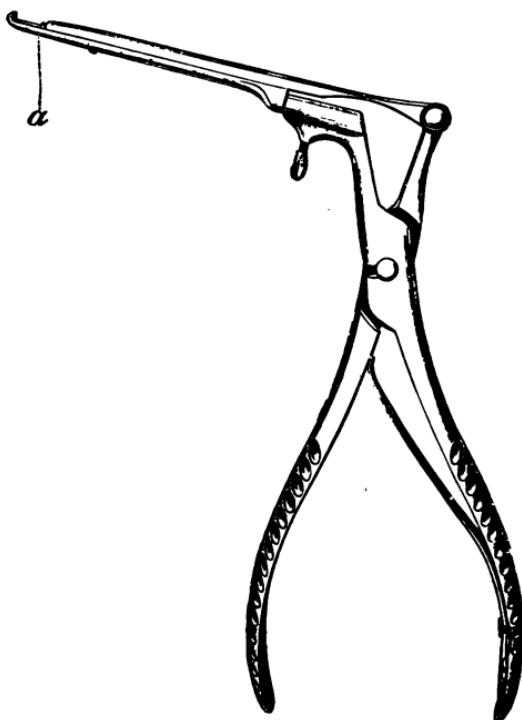


FIG. 43.—KRAUSE'S BONE PUNCH FOR REMOVAL OF OUTER ATTIC WALL
a, Stop to eject the fragments of bone.

antiseptic gauze, care being taken that the packing in the inner parts is firmly done.

After the operation slight vertigo may be complained of. This symptom is commonly transient, but it may persist for as long as two weeks. Facial palsy, more rarely than vertigo—also of a transient character—may be a sequence,

and is due either to traumatism during the operation, or to inflammatory swelling in the Fallopian canal.

The dressings are to be changed as often as they become soiled, and the antrum irrigated at each dressing.

The operation itself affords extremely satisfactory results. Of fifty consecutive cases, no fewer than forty-two were cured, and it may safely be said that, with due care, in no case is the hearing power diminished ; on the contrary, in nearly half the cases it is slightly improved. It must be admitted that there is a liability for a certain proportion of these cases to relapse, though this is not a large percentage ; and the operation itself may be considered, even when it fails in attaining its immediate object, as a useful preliminary to the radical mastoid operation.

III. Operations on the Mastoid Process.

Indications for operation on the mastoid may be divided into two great classes : (a) For acute cases, and (b) for chronic cases.

(a) *Acute Cases.*

1. Acute suppuration of the mastoid antrum.
2. Acute tuberculous disease of the middle ear.
3. Bezold's mastoiditis.

1. In all **Acute Cases of Non-tuberculous Mastoiditis**, and those which do not involve the whole or the major part of the cancellous or cellular portions of the temporal bone, the operation should be that which is designated 'Schwartz's operation,' which will be found fully described on p. 188. When a case of acute suppurative middle-ear disease becomes complicated by a secondary affection of the mastoid antrum, the temperature, if it had previously fallen, usually rises ; on the other hand, if it had not fallen, it continues high ; cases, however, occur, especially the post-influenzal type, in which extensive

destruction of the mastoid is found unattended by any rise of temperature (*vide* p. 101). Discharge from the ear may persist, may have been extremely transient, or may never have been present. A slight rigor is occasionally noticed. The patient may or may not complain of pain in the region behind the ear. In its earliest stages the symptoms of

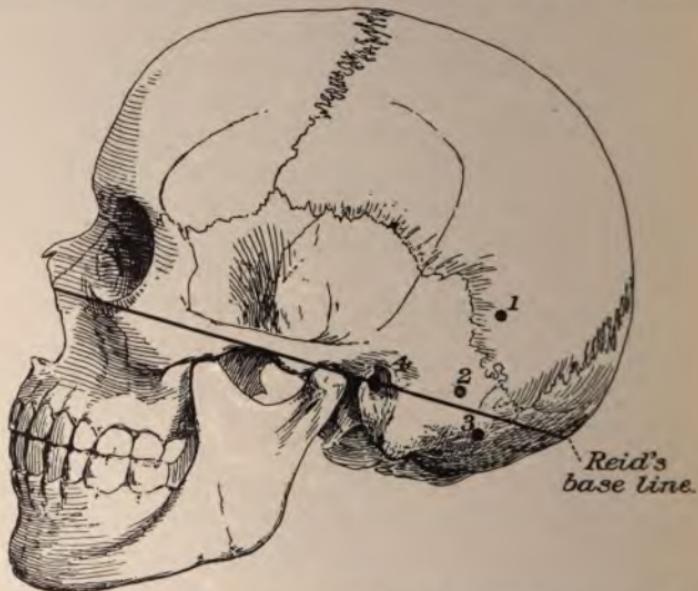


FIG. 44.—SHOWING TREPHINE CENTRES FOR OPERATIONS IN OTITIC INTRACRANIAL LESIONS.

1, Centre of trephine area for exposure of temporo-sphenoidal lobe; 2, centre of trephine area for exposure of lateral sinus; 3, centre of trephine area for exposure of cerebellum; 4, spine of Henle.

involvement of the antrum are slight and few. Besides those named there are swelling and a degree of redness of the posterior superior wall of the external meatus in its innermost portion. Tenderness will be elicited by pressure over the mastoid antrum, which lies just behind the auricle at a slightly higher level than the external meatus, and almost directly above it in children. Tenderness of the

same kind may be found in other situations, especially at or in the region of the tip of the mastoid, or at a point about $\frac{1}{2}$ inch below the site of the antrum, which may be taken to indicate either that the antrum itself is not the site of the abscess, one of the large cells in the mastoid being the affected area, or that the antrum is not the only situation in which pus exists. The skin over the mastoid process may be slightly reddened. As the disease progresses, oedematous swelling will take place, first obliterating the post-auricular cleft, and afterwards causing the auricle to project outwards; if the patient remains unrelieved, pus accumulates beneath the periosteum, and deep fluctuation may be detected; he is further exposed to the danger of the pus finding its way into the cranial cavity with its attendant risks.

2. Acute Tuberculous Disease of the Middle Ear.

—In acute tuberculous disease of the middle ear, if the treatment advocated on p. 101 is not successful in checking the disease within two weeks, an operation must be performed; but in this case it must be the complete or radical operation, to which the limit of the removal of bone is only that of the complete clearance of disease.

3. **Bezold's Mastoiditis.**—This condition will be found fully described on p. 101. When the surgeon is convinced that there is pus in the mastoid, and is of opinion, from the clinical signs, that the disease tends to the condition known as 'Bezold's mastoiditis,' he must sanction even less delay than if pus were confined to the mastoid antrum.

Influenzal Mastoiditis.—One feature in this variety of disease is that the microbic invasion of the antrum is not always preceded by a discharge from the external meatus; and another, that if the antrum is not opened surgically at the earliest indication of trouble, there is a greater risk of serious brain mischief than in ordinary acute mastoiditis. Secondary deafness and mastoid pain are complications of

influenza, and should cause an immediate inspection of the ear and mastoid process, tenderness over the mastoid being a sufficient indication for immediate operation ; the part lying immediately subjacent to the tender area ought to be carefully explored for an isolated purulent focus. A normal or subnormal temperature must be ignored in post-influenzal cases, as there is often nothing in the temperature to point to the least danger, even when pus is found in the sigmoid groove.

(b) *Chronic Cases.*

Indications for operation in chronic suppurative diseases :

1. Acute exacerbations of chronic suppurative middle-ear disease.
2. In chronic suppurative disease, where skilled treatment carefully carried out for a reasonable length of time—namely, about six months—has failed ; where, in children and young adults, adenoid vegetations have been removed without curing the aural suppuration ; and where the minor operation of ossiculectomy appears to offer no hope of cure —*i.e.*, in attic diseases, etc.
3. Where ossiculectomy has been performed, and has not cured the discharge.
4. Periodic or constantly recurring attacks of suppuration in the middle ear, especially if associated with giddiness or pain.
5. Facial paralysis in chronic suppurative conditions.
6. Cholesteatomatous degeneration in the attic and antrum.
7. Lateral vertigo on syringing.
8. Persistent mastoid pain.
9. Contraction of the external meatus, or the presence of an exostosis occluding the canal, when suppuration is present in the middle ear.
10. Mastoid fistulæ, external or internal.

11. Necrosis of the temporal bone.
12. Tuberculous disease of the middle ear and temporal bone.
13. As a preliminary to more extensive operations undertaken for the relief of intracranial complications.

1. **Acute Exacerbations in Chronic Discharge.**—In a case of chronic suppurative otitis media, with vertigo and perhaps sickness, tenderness will usually be elicited over the site of the antrum; lateral nystagmus is occasionally present, and in most cases there will be elevation of the temperature, though pyrexia is by no means constant. Swelling of the posterior superior part of the external meatus is sometimes present, while, in other cases, all discharge will temporarily cease. Tenderness over the mastoid antrum in chronic cases is of itself sufficient indication for the radical operation; much more will it be so if accompanied by any of the above symptoms.

2, 3, and 4 need no further description.

5. **Facial Paralysis.**—This indicates a necrosis in the petrous bone, and if left untreated is a frequent precursor of extension of the disease to the meninges of the brain, and so imperatively demands early operative interference.

6. **Cholesteatomatous Degeneration.**—If cholesteatomatous degeneration have attacked the accessory cavities of the ear it is not advisable to attempt to obtain a cure by means of solvents, etc. If the attic alone be involved operation may be delayed until the condition has proved incurable by the other methods.

7. **Lateral Vertigo on Syringing** may be taken to mean that the external semicircular canal on that side is exposed by erosion of the bone. This exposure of the soft parts is certainly a sufficient indication for operation.

8. In **Persistent Mastoid Pain** the object of operation may be more to relieve pain than to cure the discharge;

for here, as in any other situation, osteosclerosis frequently gives rise to neuralgic pains.

9. **Contraction of the External Meatus**, with the presence of suppuration behind the obstruction, gives rise to a condition which is probably unequalled in gravity, as a steady destruction of tissue will proceed unattended by any symptom sufficiently marked to arouse the apprehension of the patient; the most trifling febrile state, or the slightest acute inflammatory condition in the region of the ear may lead to a rapidly fatal issue.

Opening of the Mastoid Antrum.

This operation includes the opening of isolated abscesses in the mastoid, as well as abscess of the antrum.



FIG. 45.—RETRACTOR.

Designed to hold forward the concha in mastoid operations.

The operation about to be described is one that is performed *only in acute cases*, and is not suitable for chronic disease, as it has for its object the opening and drainage of an acute abscess. Usually for this reason the incision in the skin is much shorter than that required in the radical operation; the bone is not removed to the same extent, and neither the bony nor cartilaginous wall of the external meatus is interfered with. It may happen that the whole mastoid process may be disorganized, or that pus has even perforated the deeper aspects of the bone, and travelled along the fascial planes of the neck, and the area of bone removed in eradicating the disease may be in these cases greater than that

which is usual in the radical operation. However, even under such exceptional conditions, it is not necessary to remove the posterior wall of the meatus unless the disease be tuberculous.

Preliminary Measures.—The surrounding skin should be shaved for some 2 or 3 inches from the ear, and carefully washed with soft or ether soap, the external meatus irrigated with 1 in 3,000 hydrarg. perchlor. or 5 per cent.



FIG. 46.—MASTOID GOUGE.

carbolic, and packed with wet antiseptic gauze; the ear and shaven area are well washed with the same antiseptic, and a wet antiseptic dressing applied; this should be done, if possible, at least twelve hours before the time of operation. A thorough cleansing is carried out when the dressing is removed under anaesthesia, just before the commencement of the operation, and the ear well syringed out with 5 per cent. carbolic acid solution.

The skin incision should be vertical, about $1\frac{1}{2}$ inches in length, with its centre lying over the antrum, or special site of pain. The tissues are divided down to the bone, and the parts pushed back with a periosteum elevator; the sides of the wound are now held apart with retractors by an assistant. If the antrum be the seat of disease the bone is carefully cut away for an area which should be limited anteriorly by the bony meatal wall, and superiorly by the posterior end of the temporal ridge, and the opening in the bone should not be extended further than is requisite for comfortable working. The guide to the antrum is the spine of Henle or the posterior superior spine of the meatus, while a line parallel to the posterior superior part of the

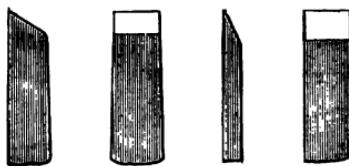


FIG. 47.—CHISEL POINTS.

It is well, when cutting away the posterior meatal wall and external attic wall, to use a high-pitched cutting edge like that on the left.

bony meatus will give the direction for the passage which must be made in the bone in order to open the antrum. When the depth of $\frac{1}{2}$ inch has been reached care must be exercised that the facial nerve be not injured. This accident will not occur if the centre of the wound corresponds with the junction of the superior and posterior walls of the meatus, and if the excavation be carried out without rashness, the bone being removed in thin films. The chisel, if used, must not be driven in perpendicularly. The surface of the wound is to be gradually enlarged superiorly, if necessary, so that the operator may work easily. A fine steel probe as a pus-searcher is constantly used, and when it enters the antrum the channel so obtained is carefully enlarged

until the whole antrum is exposed. An incision should now be made through the posterior part of the drum, and an antiseptic solution syringed through the meatus into the wound, and *vice versa*. All particles of diseased tissue are carefully removed from the antrum and any diseased cells by means of the curette, search being made for small sinuses in the bone leading to isolated foci of disease; the whole wound is swabbed out with Lister's strong solution, dusted with iodoform, and packed with antiseptic gauze. The skin-flaps are now sutured together, with the exception of a small angle at the lower point, through which the end of the dressing protrudes.

Subsequent dressings consist in keeping the meatus clean, by means of carbolic acid douches and careful plugging with antiseptic gauze, until all discharge has entirely ceased; the wound is allowed to granulate from the bottom, reducing the gauze plugging as occasion requires, but it is not necessary to allow the wound to be entirely filled up before allowing it to cicatrize over, so long as no discharge is present; the cavity left is packed with mixed iodoform and boric acid, or filled at each dressing with iodoform emulsion.

Operation in Bezold's Mastoiditis.

It is well to bear in mind that before perforation of the inner table of the mastoid process can take place certain anatomical peculiarities must exist. Such a condition cannot occur

FIG. 48.—PUS-
SEARCHER.



unless the mastoid process consists almost entirely of cells, with the minimum amount of diploë and a relatively thin outer shell of compact bone. It is invariably found that in these cases several cells of large size communicate with each other and with the antrum, one of these, more constant than the rest, being situated over the digastric groove in the under surface of the mastoid bone, and merely separated from the groove by a layer of bone scarcely as thick as an egg-shell (Fig. 14). Pus gaining entrance into the digastric fossa may find its way into other abnormal situations; it may in consequence be present at the nasopharyngeal extremity of the Eustachian tube, may burrow down the neck beneath the sterno-mastoid, or may appear behind this muscle in the suboccipital region. As a result, however, of the more general knowledge of aural disease, it is rarely that we find cases so far advanced; but the whole mastoid will more frequently than not be found full of pus when the operation is undertaken, especially where pain was previously complained of on pressure in the region of the digastric fossa.

The same preliminary treatment is necessary with regard to antiseptics and shaving that has been described for other operations on the mastoid. An incision to the bone is made commencing just above the insertion of the auricle, and is carried crescentically backwards well within the hair margin and brought down to the tip of the mastoid process. When the bone has been exposed the cortical portion should be rapidly and freely removed, when pus will be found in most, if not all, of the cells opened. By means of forceps and gouges all diseased tissue should be freely removed, no matter how wide and extensive a cavity such radical measures may cause. It may even be necessary to remove the whole of the mastoid process and to lay bare the lateral sinus for some length in order to remove all traces of the disease. The antrum should be sought for, but if the

surgeon cannot successfully differentiate this cell—a determination by no means always easy under these conditions—the bone is to be removed in order to afford an entry into the attic. The membrana tympani is now freely incised, and the middle ear and attic washed out with an antiseptic solution, and an attempt made to wash through from the post-auricular wound into the tympanum. The whole of the bottom of the cavity of the temporal bone is freely mopped with one of the strong antiseptic lotions recommended previously. The wound is now to be dusted with iodoform, filled with antiseptic gauze, and sewn up, with the exception of a small portion of the lower angle to permit of plugging; the subsequent treatment is identical with that described on p. 191.

Pus, when present in any other situation, must be evacuated and the cavity treated by ordinary surgical procedures.

Although the amount of bone removed in these cases is very large, healing is extremely rapid and the consequent deformity very slight, while the hearing is but rarely affected. If, after healing, the post-auricular deformity is unsightly, subcutaneous injections of paraffin wax may be used to restore the normal contour of the part.

The Radical Mastoid Operation.

During the last decade operations on the temporal bone have been so much improved that it is not practicable in a work of this size to apportion due credit to those workers through whose skill and ingenuity we have obtained the present excellent results. It is now customary to give the name 'radical operation' to one which is intended to remove the whole of the disease, and at the same time to throw the middle ear, the external meatus, the attic, and antrum into one large cavity.

Preliminary Preparations.—The head should be either com-

pletely shaved, or at least the affected side. The skin of the ear and of the side of the head, the neck, and face are to be thoroughly washed with ether soap and well scrubbed with a nail-brush twelve to twenty-four hours before the time of operation. At the same time the external meatus is well irrigated with 5 per cent. carbolic acid.

The external meatus is plugged with antiseptic gauze soaked in the same strength of carbolic solution, and a wet carbolic dressing placed over the ear and the side of the head.

At the time of operation the parts are again well soaped and scrubbed and treated with antiseptics in the usual way; $\frac{1}{2}$ per cent. formalin is a most useful solution. An incision is then made, commencing $\frac{1}{3}$ inch above the superior anterior insertion of the auricle, keeping the incision within the shaved edge of the hairy scalp, but at the bottom curving forwards to the apex of the mastoid process. The incision must be cutaneous for the first inch or $1\frac{1}{2}$ inches, but in the rest of its extent the knife is passed down to the bone. The reason for this difference in the anterior and superior part of the incision is to avoid dividing the temporal fascia and muscle. The flap marked out, with the whole of the subjacent tissue, including the periosteum, is drawn forwards and all bleeding points secured. It is advisable that every vessel, however small, be picked up, as oozing from the flap materially retards the later steps of the operation. The surgeon now defines the posterior and superior edges of the bony meatus, and by means of a small elevator or probe separates the upper and posterior parts of the cartilaginous meatus from the bony tube. The next step is to divide the cartilaginous meatus into anterior and posterior halves by means of parallel incisions through the upper and lower walls, these incisions being carried well up to its junction with the skin of the concha. A piece of bandage, previously sterilized, is passed through the external

meatus, and has its ends knotted into the form of a loop. This is given to an assistant, who uses it as a retractor, and pulls the external ear forwards. It is better now to define the posterior superior meatal spine (p. 3), as this is the anatomical guide to the antrum, which must be reached by cutting through the bone parallel to, and closely behind,

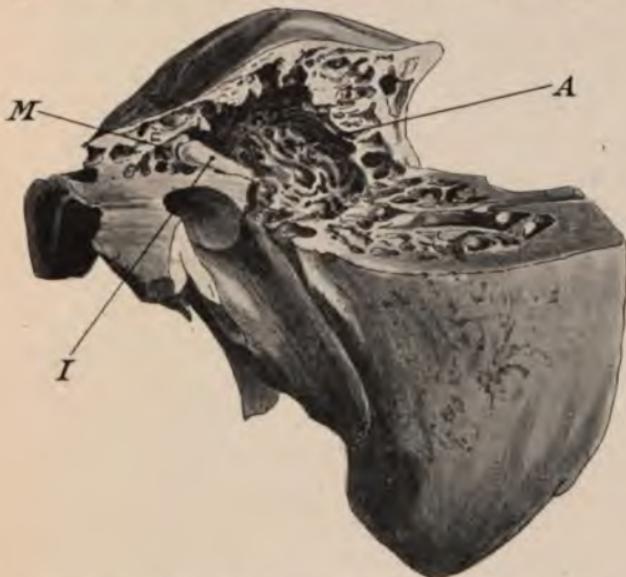


FIG. 49.—SECTION OF LEFT TEMPORAL BONE SHOWING THE CAVITY OF THE ANTRUM AND ITS RELATIONSHIP TO THE EXTERNAL MEATUS. THE CAVITY IS UNUSUALLY LARGE.

A, Antrum; *M*, head of malleus; *I*, body of incus and short process.

the posterior superior angle of the bony meatus. The cortical portion of the mastoid bone should now be removed, at the operator's option, by a large-sized gouge, by a mallet and chisel, or by the electric burr. The surgeon will find it advantageous to commence the removal of the bone towards the apex of the mastoid process, at least, on a level with the floor of the meatus, and to work gradually upwards, in order that, as the wound progresses in depth,

search is made for sinuses leading to diseased areas not yet exposed. If any are found, they must be followed up carefully. With the dental burr, chisel, or gouge the cavity is rounded off as well as possible, and all granulation tissue, together with diseased mucous membrane in the middle ear, removed freely with a curette. In fact, if it is proposed



FIG. 50.—BONE-FORCEPS FOR USE IN THE RADICAL MASTOID OPERATION.

subsequently to employ skin-grafting, no particle of mucous membrane must be left behind, as it seriously interferes with the successful growth of the graft. All the deep surfaces of the attic and other places where the bone is at all soft are thoroughly curetted, and the whole of the bony wound swabbed with Lister's strong fluid.

The flap which was formed from the posterior half of the cartilaginous meatus is now seized in its dissecting forceps, all the tissues of the external meatus included, with the exception of the skin itself, dissected off right up to the junction of the external meatal flap with the cutaneous lining of the concha. This flap of skin is now drawn backwards, and attached by means of sutures to the posterior part of the operation flap. It is advisable to stretch the external orifice of the meatus to ensure of ease in subsequent dressings. The wound is finally carefully dried, powdered with iodoform, and packed with a strip of antiseptic gauze tightly from the bottom, and its free end carried through the external meatus. The post-auricular wound is closed by means of sutures and a suitable dressing applied. It may be noted that it is not necessary to put any portion of the bandage under the chin, a plan which adds greatly to the comfort of the patient during the first twenty-four hours.

In the above operation there are two dangers to be borne in mind: one is that of wounding the lateral sinus, the other that of injuring the facial nerve. There is also the possibility of exposing the dura mater of the middle fossa; but if this last accident should happen, it is quite free from danger. The situation of the antrum is constant, and its relationship to the facial nerve is practically constant, though the position of the lateral sinus is unfortunately not so. The general configuration of the skull is largely responsible for this irregularity. In the proportionately long skulls the sinus is situated more posteriorly than in those in which the head is relatively broad. It is in the latter type that the middle fossa is most apt to be opened.

The facial nerve, coursing across the middle ear in the Fallopian canal (Fig. 2), passes a short way into the bone, which forms the posterior wall of the middle ear; it then arches slightly outwards, passing directly downwards nearly

at the same level as, but slightly external to, the posterior tympanic wall. The arch itself lies directly beneath the entrance to the aditus. The nerve should never be wounded, since it may be always avoided if, when using the chisel, its bevelled edge is kept towards the part to be removed and never driven in vertically, and the bone cut away in thin shavings.

The lateral sinus on the left side lies somewhat more anteriorly than on the right, but as a general rule the vessel lies about $\frac{1}{4}$ inch behind the external meatus. Should it be exposed during the operation, reasonable care will prevent injury, and no ill-effects will follow. If either of these two structures be injured, the following steps must be taken: If the facial nerve is severed, either the nerve must be dissected out from its bony canal for as great a distance as possible on either side of the division, and its ends brought together by sutures, or at some subsequent date the nerve may be dissected out at its exit from the stylo-mastoid foramen, where it is divided, and the cut end attached to a portion of the spinal accessory nerve, which is exposed at the same time.

Injury of the lateral sinus is evidenced by an alarming rush of blood. The haemorrhage must be temporarily checked by the finger, and a long strip of iodoform gauze pushed up *between* the sinus wall and the groove in which it lies, and a second strip of gauze inserted in a similar way downwards. This packing may be removed at the end of forty-eight hours.

Subsequent dressings consist in packing a long strip of sterilized gauze through the external meatus, so as to entirely fill the cavity. These dressings should be changed as often as any discharge shows through the external dressing of two or three layers of gauze covered by cotton-wool.

To hasten recovery, it is the modern custom to follow

Balance's teaching, which is that—about the end of the first week in children and the second or third in adults—the wound is to be reopened, and a large Thiersch's skin-graft applied to the whole bony cavity. This is a difficult and tedious procedure, but, if carefully carried out, will repay the trouble, and in the majority of instances is said to obtain a much more rapid convalescence and perhaps a more certain cure than if the cavity were allowed to cicatrize.

The after-treatment, if grafting is not employed, consists in changing the dressings less and less frequently as the discharge lessens, being particularly careful to plug firmly to the bottom of the wound and to fill it equally in all directions, for unless this be done granulation tissue will form, and so diminish its size as to eventually completely occlude the cavity. In fact, cases do occur in which this tendency to excessive granulation-tissue formation is so exuberant and persistent that, despite all efforts, the cavity is completely obliterated. For the first two weeks it is absolutely necessary that all fluids used for irrigating the operation cavity should have strong germicidal and somewhat caustic power. Two solutions which possess these properties are 5 per cent. solutions of carbolic acid and $\frac{1}{16}$ per cent. of corrosive sublimate. It is absolutely necessary to bear in mind that, should septic changes be allowed to occur, the danger to which the patient is subjected is as great, if not greater, than if no operation had been performed.

When it is proposed to graft, it is well that the solutions used for irrigation of the cavity between the time of the first and second operations should not for the last few days be of caustic strength, as they tend to harden the granulation tissue which is formed, and do not leave a suitable surface on which to graft. The grafts are taken from the inner surface of the thigh, and too much care cannot be exercised in rendering the surfaces from which they are

taken aseptic, the least neglect of the most scrupulous precautions being apt to lead to an increase of suppuration in the cavity after the graft has been inserted, and to the death of the graft itself. The part from which the graft is to be cut should be thoroughly washed with ether and soft soap, or with ether soap, forty-eight hours before the operation, scrubbed with a nail-brush, sponged with a mixture of ether and alcohol, and, finally, an antiseptic dressing carefully applied and kept in its place by a spica bandage. If the patient is one whose social position or habits of life have prevented the regular use of baths, a second cleansing similar in all respects to the first should be carried out twenty-four hours before the operation, and a fresh dressing applied.

The post-aural wound is reopened, the dressing removed from the cavity, which is then well irrigated with a sterilized saline solution and curetted to remove all proliferating granulation tissue. It is then again cleansed with saline solution, and packed with gauze well soaked in adrenalin in solution, with a little pressure in order to check all bleeding by the time that the graft is cut and ready for application. The dressing from the thigh is removed, and the part from which the graft is to be cut sponged again with alcohol and ether. A sterilized bar of wood or iron is laid across the thigh parallel to and just below Poupart's ligament, and kept pressed firmly down and held by an assistant. The operator then with his left hand draws the skin of the thigh downwards, so as to render the surface flat. The graft is now cut with a heavy wide-bladed Thiersch's knife, and should be of sufficient size to line the whole cavity and obviate the necessity of employing a second. A little saline solution dropped upon the razor and the thigh as the graft is being cut assists in the ease with which the skin may be cut, and tends to prevent curling of the ablated skin. The graft is now transferred

to a shallow dish containing warm sterilized saline solution. A dressing is applied to the thigh by an assistant, the most comfortable one being a piece of lint spread with aseptic ointment. The operator now exposes the mastoid wound, and, when all oozing is stayed, he proceeds to apply the graft, which is taken up on a large section-lifter and applied over the bony wound in such a way that its edges rest on the fleshy parts, above as well as in front and behind, any folding of the graft which may have taken place being promptly corrected. The graft is carefully worked down into the deeper parts of the wound by means of long needles fixed in handles, and is then pressed into its deeper recesses either by means of needles, or by instruments specially constructed for the purpose, any moisture which has accumulated beneath the graft being sucked out by means of long glass pipettes, which are also useful in securing a close adaptation of the graft to the walls of the cavity.

Ballance recommends that the surface of the graft, after it has been applied in the manner described, be covered with a layer of thin gold-leaf. This procedure, however, is not necessary, as the wound may be plugged with a strip of gauze previously well permeated with sterilized parolein, which is firmly pressed down into the wound, thus keeping the graft in close apposition to the bone. The remains of the graft, which would otherwise lie outside the wound, are carefully turned forward over the gauze plug, so that the inner aspect of the flap not covered by the piece of skin taken from the posterior meatus shall receive an epithelial covering. It may be necessary, however, to apply a second small skin graft to this part. The wound is reclosed with sutures, and an antiseptic dressing applied.

It ought to be borne in mind that during this grafting operation no antiseptics are used, since they diminish the vitality of the graft.

The dressing may be changed on the second day—preferably on the third—the wound irrigated with sterilized saline solution or weak boracic lotion, and re-plugged. Occasionally the whole of the graft comes away within the first fortnight. The reason of this will be because : (a) Too powerful antiseptics were used previously to the operation ; (b) the graft was too thick ; (c) a certain amount of fluid was left beneath the graft, which prevented its adhesion.

Besides the method of dealing with the external meatus which has been described, two other methods are worth consideration. The first is to remove the posterior half of the external meatus entirely. This rather shortens the operation, and at the same time removes the ceruminous glands, which, if transplanted and removed from their natural support, may give rise to trouble by filling up the operation cavity with a mass of cerumen.

The second method of dealing with the external meatus is to divide it horizontally through the middle of its posterior wall, and vertically at the junction of its posterior half with the auricle. When this procedure is adopted great care must be taken to keep the meatal flaps pressed upwards and downwards until they shall have become attached in their new situations.

The clinical results of the radical mastoid operation are extremely good, and in a large majority of cases complete and lasting cure is obtained. It is most rare for the hearing power to be injured, but, on the contrary, it is more frequently markedly enhanced, whilst the improvement in the general health of the patient is obvious to the most casual observer. Occasionally, however, it is necessary to operate a second or even third time ; but there is reason to believe that by the aid of skin-grafting such cases will become comparatively rare, and also the occurrence of post-auricular sinuses, due to the operation, will be prevented.

CHAPTER X

MALIGNANT DISEASE OF THE EAR

MALIGNANT disease of the external ear may take the form of violent ulcer, malignant warts, squamous-celled carcinoma or sarcoma. Malignant disease of the external auditory meatus may take the form of squamous-celled carcinoma or adeno-sarcoma.

Squamous-celled carcinoma may originate either in the form of an ulcer or a warty growth, rapidly breaking down, in either case the patients being usually past adult life, and presenting themselves with a foetid and usually sanguous discharge from the ear, which will be accompanied by severe pain, though this is not always very pronounced in the earlier stages of the growth. Facial paralysis will often be an early symptom. On examining the external meatus, in the case of carcinoma, if there is no obvious growth, a sinus with foul edges may be seen in the wall of the meatus, from which the discharge exudes. Besides the age of the patient and the suspicious appearance of the growth, the character of the discharge, the rapid incidence of a hectic appearance, and the presence of enlarged glands in the neck, will determine the diagnosis, which very rarely presents any great difficulties. In the later stages, the rapid destruction or involvement of the surrounding parts, the formation of proliferating granulations, the profuse offensive

sanious discharge, the appearance of the patient, the rapid emaciation, present so clear a picture of malignant disease that error is impossible.

Should the disease be of the adeno-carcinomatous variety, originating in the tissues of the external meatus, it will rapidly occlude the canal, with or without the formation of a malignant polypus bathed in a foetid discharge.

At this time removal of the growth should be attempted, all anatomical landmarks being disregarded in attempting to obtain complete removal. If the middle ear be the seat of the disease, or if this originates in the surrounding bone, it may be of a myxo-sarcomatous nature, which occurs in early childhood, sarcomatous or carcinomatous, the temporal bone in either case becoming rapidly involved; and the condition may be one which resembles that of an early acute mastoiditis, though the age of the patient with cancerous disease is usually later than that at which acute mastoiditis is found, and at the same time the absence of any history of suppuration or of illness suggests influenza, and the general condition of the patient, together with a careful examination of the deeper parts of the meatus, will usually enable the surgeon to recognise the serious disease which is present, and prevent him from making an error in diagnosis. It is but rarely that suppurative disease of the middle ear is followed by malignant disease. The history of a case of malignant disease will usually be that the patient has suffered a considerable time from pain and a certain amount of discomfort in the mastoid bone and surrounding parts, that a more or less diffuse swelling has made its appearance behind the ear, which has gradually increased, together with the existence of glandular infection.

It is hopeless to attempt the removal of malignant disease starting in the deeper parts of the temporal bone, so that the surgeon's efforts must be directed towards obtaining euthanasia.

CHAPTER XI

DISEASES OF THE INTERNAL EAR

THE internal ear consists of the membranous labyrinth, the cochlea, vestibule, and semicircular canals, which receive the terminations of the auditory nerve; in diseases of the internal ear are included those of the auditory nerve itself. The auditory impressions are received by the cochlea, while the semicircular canals are largely concerned in the maintenance of equilibrium. We detect disease of the cochlea, as distinguished from diseases which prevent sound-waves from reaching and from stimulating the nerve-endings of that part of the auditory nerve which supplies the cochlea, by means of the various sound-testing investigations. These have already been described in the chapter on Examination of the Ear. The more important diagnostic tests for internal ear deafness are, when the hearing power for speech is greatly reduced: material diminution or complete absence of bone-conduction for Politzer's acoumeter or the watch; loss of high tones as shown by Galton's whistle; diminution of or loss of bone-conduction for tuning-forks, especially those of high pitch; Rinne's test (p. 50) is positive, but at the same time there is a shortened perception for the tones of the tuning-fork, and if the deafness is one-sided the fork in Weber's test is referred to the sound side. The Eustachian tube will be patent, inflation

of the middle ear will give no improvement, and there may be no pathological changes in the middle ear. But the difficulty of demonstrating conclusively a case to be one of internal ear-deafness is materially assisted by negative evidence of middle-ear trouble.

Diseases which affect the internal ear are either primary or secondary, the former being much the more rare. They may consist in haemorrhages and in primary inflammations; whilst as secondary affections may be taken traumatism in all its forms, and the effects of general diseases, such as syphilis, rheumatism, gout, malaria, leucocythaemia, etc. But of all the causes acting on the internal ear, the most prolific are diseases of the middle ear, more especially otosclerosis, which, although it is placed for convenience amongst the diseases of the middle ear, affects at least equally the internal ear. Certain toxic agents distinctly affect the auditory nerve, such as quinine, the salicylates, opium, tobacco and alcohol. The specific fevers, especially typhoid fever, mumps, influenza, diphtheria, and cerebro-spinal meningitis, may be the cause of acute labyrinthine changes, causing sudden and permanent deafness.

Syphilis of the Internal Ear.—Acquired syphilis comparatively rarely affects the organ of hearing, but may do so both in the secondary and tertiary stages. In the former there is a general hyperæmia of the mucous membranes, which will invariably rapidly yield to treatment, and the deafness soon pass away, and requires no treatment directed towards the internal ear itself. In the tertiary stage, the acquired disease will cause a mixed otosclerosis and labyrinthitis with severe deafness and Menière's symptoms. Hereditary syphilis, moreover, is a frequent cause of internal-ear disease.

Here the period of onset is in early adult life, usually shortly after, or even during the progress of, an attack of interstitial keratitis, and it may be that the patient is

even at that time being treated with antisyphilitic remedies. The progress of the disease is one of extreme rapidity, being bilateral and very intractable. Sometimes at the end of a week, or even less, the patient is absolutely deaf. Our treatment must in consequence be equally vigorous, and while mercury should not be discontinued, iodide of potash must be given, and is best administered in 5-grain doses in hot water after meals. Besides these specific remedies, pilocarpine should be employed ; nor should this be delayed to observe the result of our other treatment. It should be administered in the form of hypodermic injections, commencing with $\frac{1}{20}$ grain injected under the skin over the mastoid process on either side on alternate days, increasing the dose rapidly up to $\frac{1}{8}$ grain, which should be considered the largest dose from which benefit is likely to be derived. On account of the profuse perspiration which is set up by this drug, the patient should be confined to the house during the treatment. If the patient be anæmic, tartrate of iron and bark should be combined with the antisyphilitic drugs. When pilocarpine treatment is not of any benefit at the expiration of three weeks, it should be discontinued; otherwise it may be persisted in as long as improvement is noticed. Strychnine, the dose of which should be rapidly increased, should be tried if other drugs fail. The steady increase of the strength of the dose will usually enable the patient to acquire a tolerance for the drug, which may be increased to 12 minims of the liq. strych. thrice daily. But whatever treatment is adopted, it must be recognised that the great majority of cases will not show any improvement in acquired tertiary disease of the labyrinth.

Gout.—Gouty disturbances of the internal ear are more frequently connected with subjective noises than with deafness, unless it is combined with chronic non-suppurative disease, and it may then be, and frequently is, accompanied by severe attacks of vertigo, which are, though partly due

to the internal trouble, accentuated by the general dyscrasia. In considering any particular case, one must give due weight to any organic disturbances present, such as a large and flabby heart. But, while giving due attention to the gastric or circulatory disturbances, it will be desirable at the same time to employ such remedies as will lessen the aural trouble. These will consist in counter-irritation behind the ear, either by the action of blisters or rubefacients. If the latter are employed, the skin should be made tender, but vesication avoided; whilst the internal administration of antilithics together with alkaline nose washes should be ordered, and the naso-pharynx regularly kept painted with Mandl's solution (see Appendix).

Anæmia.—A deficient supply of oxygen in the blood causes frequently a diminution in the functional activity of the cochlea, in common with the like effect experienced by the other organs of the body, and with this anæmic condition of the labyrinth is closely associated those forms of *functional* or *hysterical* deafness. It is, however, necessary in anæmic cases to be particularly careful as to how much direct treatment is adopted towards the auditory nerve. In these cases the tuning-fork tests, which show most erratic results often with loss of hearing-power for certain tones, will convince one immediately that the disease is of neurotic origin, the patient being able to hear a certain amount of conversation, especially if the questions asked are relevant and in a low, clear voice; whilst the tuning-fork may not be heard at all if applied to the mastoid, and any other sound test will be pronounced inaudible.

In these cases, besides any general treatment, such as the administration of arsenic and iron, a mild counter-irritation behind the ear will be extremely useful, but the use of the catheter or politzerization is absolutely contra-indicated until such time as the patient's nervous system is more under control. In order to obtain this result there is no more

valuable remedy than valerian, and, as its nauseous taste has no therapeutic advantage, it may be administered in the form given in the Appendix.

Malaria.—In acute attacks of malaria marked deafness is often a prominent and well-marked symptom. This, however, is frequently due to a large extent to the excessive administration of quinine. When this is the case, if the internal ear be not immediately affected by the disease itself, complete recovery of the hearing will follow the cessation of the exhibition of quinine. In other instances, even when no quinine has been administered, a marked residual deafness remains, and in these a characteristic reaction of the tuning - fork tests will be noted ; that is to say, there is a great reduction in the length of bone-conduction compared with the aërial conduction.

This form of deafness will generally rapidly yield to regular catheterization, together with the internal administration of strychnine and arsenic. The strychnine should be administered, as in other cases of ear-deafness, in rapidly increasing doses.

This form of deafness is probably due to the changes which take place in the blood in malarial affections.

Increase of Labyrinthine Pressure.—An increase of intralabyrinthine pressure causes a disturbance of hearing if it occurs in the cochlea, and of equilibrium if it occurs in the semicircular canals.

CAUSATION.—Increased labyrinthine pressure may follow any of the exanthemata, typhoid fever, mumps, pneumonia, and meningitis. It may be the result of a sudden effusion of fluid without any well-determined cause, or, especially in middle-aged and elderly people, from the effect of sudden cold, gout, or Bright's disease. It may be caused by sudden driving in of the stapes by rapid raising of the atmospheric pressure in the external meatus, as when working in compressed air.

SYMPTOMS.—Deafness, coming on during any acute illness, will often not be recognised until the acute symptoms of the general disorder have subsided. When, however, it occurs in comparative health, the patient will suddenly lose the hearing of one or both ears, very

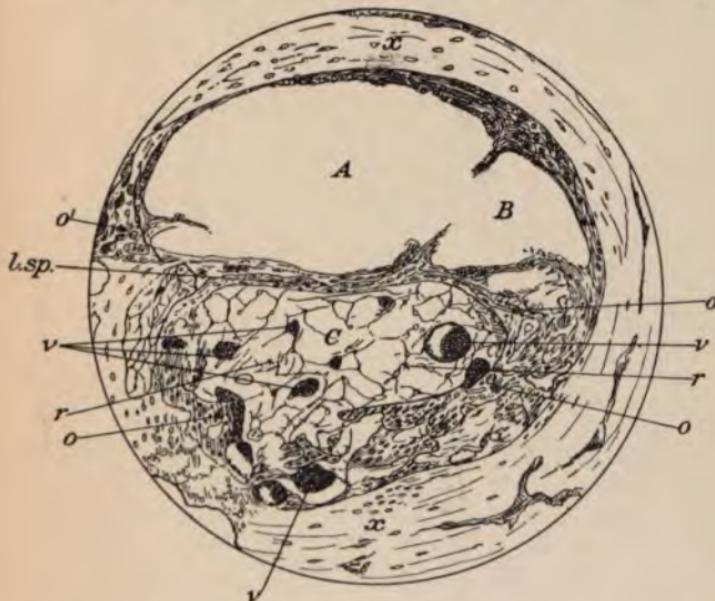


FIG. 51.—LEUKÆMIA. SECTION OF COCHLEA, LOWEST PART.

A, Scala vestibuli; B, canalis cochlea; C, scala tympani; r, delicate reticulum (organized clot) in scala tympani, containing numerous thin-walled bloodvessels (v); o, newly-formed bone in scala tympani; o', newly-formed bone in scala vestibuli; x, normal bone; l.sp., lamina spiralis.

frequently at night. Vertigo is a common symptom, though it is frequently transient in character. The tuning-fork, even when vibrating strongly, will either be not heard at all, or only barely perceived by bone- or air-conduction.

Subjective symptoms are occasionally present, and are very distressing.

TREATMENT.—In this class of case, the hypodermic injection of pilocarpine, as recommended on p. 208, should be employed. For the relief of tinnitus, hydrobromic acid (doses of ʒ.i.), conium, and strychnine, are the more useful remedies, while vesication or counter-irritation over the mastoid forms a useful aid.



FIG. 52.—SECTION OF COCHLEA, HIGHER UP THAN FIG. 51.
A, Scala vestibuli; *B*, canalis cochlea; *C*, scala tympani; *o* and *o'*, new bone formation.

Leukæmic Deafness.—Patients suffering with leukæmia are not infrequently seized with sudden deafness and vertigo, together with severe tinnitus. This is caused by an exudation of leucocytes into the perilymphatic spaces, or even into the membranous labyrinth itself. Should the patient survive for any length of time, these leukæmic haemorrhages

will be followed by the formation of new bone, sometimes to such an extent that the semicircular canals are represented by the membranous canal alone, whilst in the cochlea, the organ of Corti, together with the membrane of Reissner, may be converted by the same changes into bone (Fig. 52).

Menière's Disease.—Menière's disease, as originally

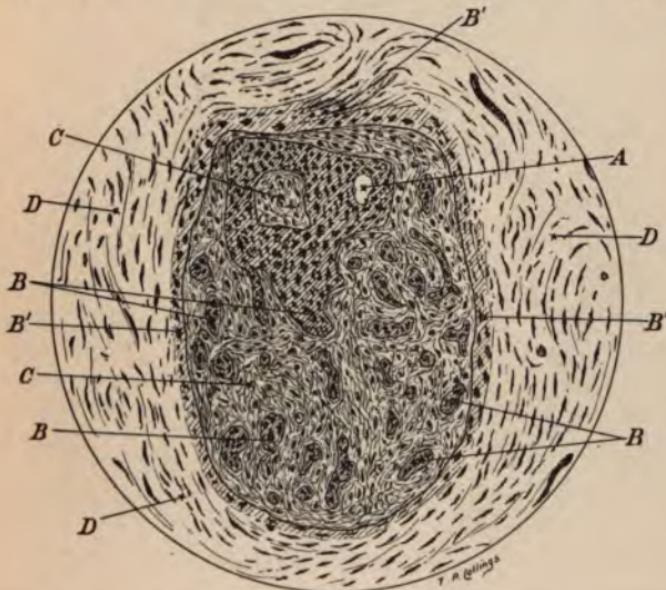


FIG. 53.—SECTION THROUGH HORIZONTAL SEMICIRCULAR CANAL.

A, Membranous semicircular canal; the perilymphatic space is completely obliterated by new bone (*B*) and newly-formed fibrous tissue (*C*); *B'*, new bone formation beneath endosteum; *D*, normal bone.

described, was characterized by vertigo, vomiting, fainting and tinnitus, the result of a haemorrhage into one of the semicircular canals. This is the so-called apoplectiform variety, and may be said in most instances to destroy, if it involves the anterior part of the labyrinth, the hearing, whilst if it involves the posterior half the hearing is not of necessity materially

affected. It also occurs as a sequel to chronic middle-ear disease, in which dizziness, vomiting, subjective noises, together with a sudden increase in the deafness, form the classical symptoms, apart from the loss of consciousness present in the apoplectiform variety, it being usually absent in the secondary.

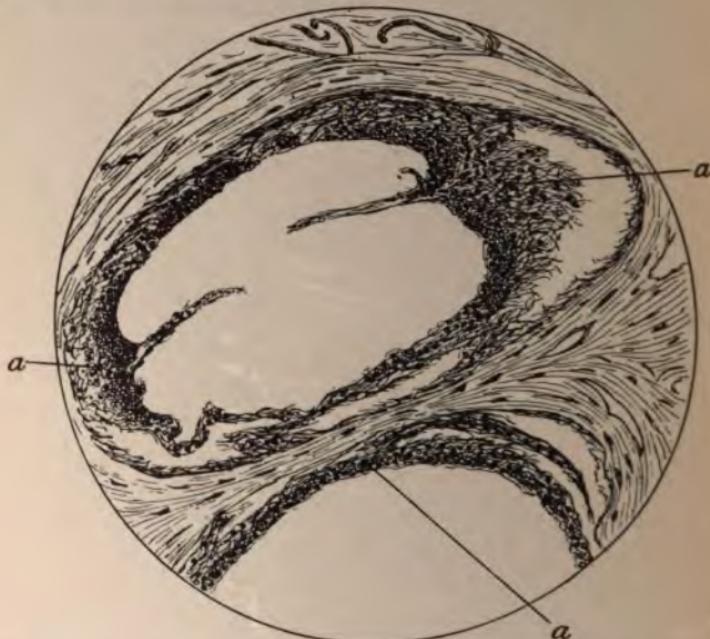


FIG. 54.—SECTION OF APEX OF COCHLEA, SHOWING LEUKÆMIC CLOT COMMENCING TO ORGANIZE.

TREATMENT.—Iodide of potassium and, later, quinine in large doses, are the more serviceable internal remedies, though if there be much nervous excitability the bromides will be superior. The effect of pilocarpine may also be tried. The only local treatment which appears to have any beneficial effect is the use of the constant current, one pole being placed over the mastoid process and the other at the back of the

neck. Very weak currents should be employed at the commencement, and the sitting should be of short duration, but should be repeated daily. This should not be employed at the commencement of the disease.

Inflammation of the Labyrinth, or Otitis Interna.—This condition is usually secondary to suppurative disease of the middle ear, but may be a primary affection, and will either be the prelude to acute septic infection, or will be followed by a necrosis of the labyrinthine capsule, which has already been alluded to as a sequel to suppuration of the middle ear.

The chief symptoms will be high fever and intense vertigo, the latter symptom, if the patient recover, continuing for a length of time, and being usually accompanied by severe tinnitus. The vertigo will eventually pass away, but the tinnitus will remain until the diseased bone is removed.

Primary New Growths of the Internal Ear.—Primary new growths of the internal ear are comparatively rare. They may be sarcomata, neuromata, or epitheliomata. They will rapidly spread into the surrounding bone, and will, if the disease be malignant, penetrate into the cranial cavity. If the growth, however, be innocent, as a neuroma, its symptoms will vary according to the site of the growth.

DEAF-MUTISM

Deaf-mutism is either congenital or acquired. The congenital form is due to a non-development of some portion of the labyrinth, the most constant of these errors of development being absence of one or more of the semicircular canals. In these patients no perception of sound can be discerned. They may be tested with loud sounds, as bells and whistles, or by the sharp sound produced by a piece of flat steel bent rapidly to and fro.

No treatment can be of any avail in these cases, and the sufferers should be instructed early in lip-reading.

Acquired Deaf-Mutism.—Acquired deaf-mutism is due to some inflammatory change either in the middle ear, the labyrinth, or within the cranial cavity. If a child has not learnt to speak, and suddenly loses his hearing, he will become a deaf-mute. Such a calamity occasionally follows acute diseases, as meningitis, scarlet fever, mumps, and the exanthemata in general ; concussion of the brain will sometimes cause it.

TREATMENT.—In patients in whom all perception of sound is entirely lost, as carefully determined by the use of hearing tests, we have little to hope for from treatment ; in sufferers who retain any perception of sound whatever an endeavour should be made to restore the function, and in such cases adenoid vegetations, if present, should always be removed. At the same time it must be clearly understood by the parents or friends that the operation in itself is only an adjunct to aural treatment, which consists in regular inflation for two or three months, and in the administration of *nux vomica*, with occasional doses of *hydrarg. c. creta.* It is, unfortunately, rarely that we obtain any result by this treatment, but, nevertheless, it should be given a trial. If it fail, the child is to be put under proper instruction in lip-reading.

Urbantschitsch has recently re-introduced a form of treatment in vogue in the early part of last century, which is to enable those deaf-mutes who still possess a dormant remnant of hearing power again to exercise that remnant, and to build upon it an increased audition. This end is obtained by the use of methodical acoustic exercises, which may be said to have a threefold object : First, to awaken attention to acoustic impressions ; secondly, to build up differential hearing ; and, thirdly, to increase acoustic excitability. No case should be considered unsuitable until the acoustic

exercises have been tried. They are not so suitable in school-children as they are in later life on account of the great pains which must be taken in order that the exercises may produce any result, and the large amount of time required. Neither can the result be foretold in any individual case, nor should the inability to hear tuning-forks through the cranial bones be considered as a bar to treatment.

The greater the difficulty there is in arousing the perception of sound, the more are special exercises required. These latter may be omitted in the event of the patient hearing his own voice or perceiving ordinary sounds. If the slightest acoustic perception is awakened by the exercises, the case immediately becomes suitable for further treatment.

The method of Urbantschitsch is briefly as follows: Two vowels are selected—say *a* and *o*, as they are the more readily understood. The one to be used is first indicated to the patient by the lips, and then is spoken into the ear in a loud and prolonged voice. This must be repeated until the patient perceives the sound. This may not be for several sittings, and it is better that the sittings should not be too much prolonged, but they may be often repeated. As soon as the first sound is heard and pronounced by the patient, the second vowel sound is employed to enable him to commence arriving at a differentiation of sound. One vowel after another is added, until the patient has mastered all the vowel sounds. At each subsequent lesson a consonant is added to a vowel, until the rudimentary vowel and consonant sounds are both perceived and differentiated. Gradually more syllables and combinations of sounds are employed until words are formed, and eventually complete sentences, the distance from the ear being increased as the exercises progress, and as soon as possible lip-reading is abandoned, and the exercise becomes purely acoustic. As

soon as possible also it is advisable to connect the sounds made with some object which will appeal to the other senses of the sufferer. Urbantschitsch himself says that the lessons should not last more than five minutes to commence with, nor occur oftener than once a day; but as the patient progresses, so may the time limit and frequency of the séances increase. Above all other factors, regularity and the close adherence to a system are necessary; also the teacher requires to possess a clear and sonorous voice.

CHAPTER XII

LIFE ASSURANCE

The Influence of Diseases of the Middle Ear on Life Assurance.

It will be advisable to consider this question under the four following symptoms: Deafness, vertigo, tinnitus, and suppuration.

Deafness.—The influence of deafness directly upon life-expectation is small, but a deaf man cannot be considered as an absolutely first-class life. He runs necessarily a greater risk of accident than does a man in possession of all his faculties ; and severe deafness in a young person who is insuring his life for its whole period should certainly subject him to a moderate increase in the premium—that is to say, an addition of about five years to his age ; a young individual afflicted with otosclerosis should receive at least three years' addition. In later life—fifty years and upwards—the load need be no more than three years for absolute deafness.

Vertigo.—Vertigo, especially if severe and if the attacks are accompanied by Menière's symptoms, will necessitate a very heavy increase in the premium, or even an absolute rejection of the life.

Tinnitus.—Tinnitus, uncomplicated, is only an important factor when the applicant for assurance is of a

neurotic temperament, and has begun to find the tinnitus intolerable, or when the tinnitus has commenced to take the form of voices; in the former instance the possibility of suicide must be taken into account, and in the latter the probability of the onset of insanity.

Suppurative Disease of the Middle Ear. — After occurrence of a single attack of acute otitis media, followed by complete restoration to health, a person is not rendered unfit for life assurance at the usual rates.

An applicant who has suffered from chronic purulent disease of the middle ear in whom the perforation has healed, and who has been free from symptoms for five years or upwards, also needs no addition to his premium. An applicant in whom a perforation exists, but in whose condition there has been no active change for three years, may be accepted with a slight addition to the premium. All candidates who are the subjects of a chronic suppurative otitis media, no matter where the perforation is situated, nor how scanty the discharge, nor how long the periods between recurrent attacks, should be absolutely rejected. This rule of practice may be modified to this extent: If an applicant place himself under treatment, and report himself at a later date as having been cured for more than two years, the medical referee may then accept the proposal with an addition of five to seven years to the life. On the other hand, if the applicant has submitted to the radical mastoid operation with a successful result, no addition need be made to the assurance premium. This operation can only be called successful from an assurance point of view when the cavity remains dry and free from cholesteatoma, and is capable of free inspection through the external meatus. No applicant who has had an abscess of the brain should be accepted until a period of at least ten years has elapsed since the symptoms subsided.

The disease of the external ear which would cause

rejection would be the occurrence of malignant disease. Lupus of the external ear would entail the applicant being deferred until the disease had been eradicated and had remained cured for two years.

The general principle underlying the treatment of applicants for life assurance with suppurative otitis media is that the applicant is suffering from a curable disease, which as long as it remains untreated is dangerous to life, and that to an extent which it is impossible to estimate.

APPENDIX

POWDERS.

FOR NASAL LAVAGE.

1. Rx Sodii chlorid. }
Sodii bibor. }
Sodii bicarb. }
Sach. alb. }
3*i.* in 3*x.* of tepid water.
2. Tabloid nasal. Phenol compound.
(Burroughs and Wellcome.)

FOR SYMPTOMS OF MENINGEAL IRRITATION.

3. Rx Hydrarg. subchlor. }
Quinin. sulph. }
gr. x.

The powder to be given every four hours till temperature falls.

4. Rx Quinin. sulph. gr. xx.
Ft. pulv. Take one every four hours.

For use in very severe cases of Menière's disease.

MIXTURES.

5. Rx Liq. hydrarg. perchlor. ... 3*i.*
Sp. vini rect. 3*i.*
Glycerin. 3*i.*
Ext. cinchona liq. M*xx.*
Aquam ad 3*i.*

M.; ft. dosis. Thrice daily.

FOR USE IN TINNITUS.

6. Rx Tinct. valer. ammon. ... ʒss.
 Sp. ammon. aromat. ... ℥x.
 Aquam ad ʒi.
 M.; ft. dosis. Thrice daily.

7. Rx Ac. hydrobrom. dil. ... ℥xxx. ad ʒi.
 Sp. chloroform. ℥vii.
 Aquam ad ʒi.
 M.; ft. dosis. Thrice daily.

8. Rx Liq. strychnin. hydrochlor. ℥v.
 Ac. nitrohydrochlor. dil. ... ℥v.
 Aquæ ad ʒss.

M.; ft. dosis. Thrice daily after food.

Increase the dose by ℥i. until ℥xii. per dose is reached.

LOTIONS.

FOR SYRINGING THE EAR.

9. Rx Lysol $\frac{1}{2}$ to 2 per cent.
 10. Rx Creolin $\frac{1}{2}$ to 2 per cent.
 11. Rx Izal to 10 per cent.
 12. Rx Sol. hydrarg. perchlor. ... $\frac{1}{30}$ to $\frac{1}{10}$ per cent.
 13. Rx Sol. hydrarg. biniod. ... $\frac{1}{10}$ to $\frac{1}{4}$ per cent.
 14. Rx Formalin $\frac{1}{40}$ to $\frac{1}{2}$ per cent.
 15. Rx Ac. borici gr. v.-xx. ad ʒi.
 16. Rx Glycerin. ac. borici ... }
 Glycerin. ac. carbolici. ... }
 Aquam ad ʒv.
 M.; ʒiv. in Ȑā ʒiv.

GUTTÆ.

17. Rx Sp. vini rect. ʒi.

Thirty drops to be warmed and dropped into the ear.

18. Rx Ac. borici gr. x.
 Sp. vini rect. ʒi.

As in formula 17.

19. Rx Ac. salicyl. gr. v. ad gr. xx
 Sp. vini rect. ʒii.
 Liq. ammon. acetat. ... ad ʒi.

20. Rx Peroxide of hydrogen (10 vols. strength).
 As in formula 17.

FOR SOFTENING CERUMEN.

21. Rx Glycerin. }āā ʒi.
 Aquæ dest. }āā ʒi.

22. Rx Sodii bicarb. gr. xxx.
 Glycerin. ʒii.
 Aquam ad ʒi.

As in formula 17.

ANÆSTHETIC SOLUTIONS.

AURAL USE. GRAY.

23. Rx Cocaine gr. x.
 Aniline oil ʒi.
 Rectified spirit ʒi.

This solution soon changes colour from absorption of water.

24. Rx Sol. eucaïnæ, 8 per cent. ... }āā ʒss.
 Sol. cocaine, 10 per cent. ... }āā ʒss.

REMEDIES FOR USE IN OTALGIA.

25. Rx Pil. belladonnæ gr. $\frac{1}{6}$.
 Take one three or four times daily.

26. Rx Opium aural ovoid. (Bullock and Co.)

One to be pushed into meatus. To be repeated in three hours' time if required.

27. Rx Chloroform.

Ten minims to be dropped into an egg-cup and place over auricle.

28. Rx Phenacetin gr. x.
 Take one powder thrice daily.

29. *B* Antipyrin gr. xx.
As in formula 28.

30. *B* Morphia (hypodermic)

COUNTER-IRRITANTS.

31. *B* Linimenti iodi } $\ddot{\text{a}}$ partes
Pigmenti iodi } $\ddot{\text{a}}$ equales.

Paint the mastoid daily until soreness is produced.
Repeat the process as soon as the part is again sound.

B Quinin. bisulph. gr. $\frac{1}{2}$.
In forma pulv.

Powder on raw surface after blistering, and cover with oil-silk.

32. *B* Liniment. iodi } $\ddot{\text{a}}$ partes
Tinct. capsici } $\ddot{\text{a}}$ equales.
As in formula 31.

33. *B* Ethyl chloride.

Use as a spray over mastoid thrice daily.

INTRATYMPANIC INJECTIONS.

34. *B* Sodii bicarb. gr. vii.
Glycerin. } $\ddot{\text{m}}$ xxx.
Aquæ dest. } $\ddot{\text{m}}$ ii.ss.
M. ; ft. inject. Use 3 minims warm.

35. *B* Pilocarpin. mur. gr. iii.
Aquam dest. ad $\ddot{\text{m}}$ ii.ss.
As in formula 34.

36. *B* Pot. iod. gr. i.
Aquam dest. ad $\ddot{\text{m}}$ i.ss.
As in formula 34.

VARIOUS.

MANDL'S SOLUTION.

37. Rx	Iodi (cryst.)	...	...	gr. vi.
	Pot. iod.	...	...	gr. xx.
	Menthol	...	...	gr. v.
	Glycerin.	...	...	3i.

M. ; ft. pigmentum.

IODOFORM EMULSION.

38. Rx	Iodoformi	...	...	5i.
	Lanolini	...	...	3i.
	Ol. petrol.	...	...	3vi.

M.

LISTER'S STRONG SOLUTION.

39. Rx	Hydrarg. perchlor.	...	...	$\frac{1}{5}$ per cent.
	Ac. carbol.	...	...	5 per cent.
	Aquam	...	...	ad 100 per cent.

SALICYLIC PASTE FOR USE IN ATTIC CHOLESTEATOMA.

40. Rx	Ac. salicyl.	...	...	20 per cent.
	Creasoti	...	...	20 " "
	Emp. plumbi	...	...	60 " "

M.

LASSAR'S OINTMENT FOR ECZEMA.

41. Rx	Salicylic acid	...	...	gr. v.
	Resorcine	...	...	gr. v.
	Ichthyol	...	...	gr. x.
	Lanoline			
	Vaseline			
	Zinc oxide		...	aa 3ii.
	Starch			

In moist eczema the salicylic acid should be omitted.

INDEX

ABNORMAL conditions occurring as sequelæ to chronic middle-ear suppuration, 158

Abscess, cerebellar, 171
 extradural, 164
 mastoid, 100
 otic cerebral, 166

Acoumeter, 51

Acute diffused inflammation of external meatus, 74
 symptoms of, 74
 treatment of, 75

Acute Eustachian obstruction, 131

Acute exacerbations in chronic discharge, 187

Acute inflammation of middle ear, 92
 pathology of, 93
 symptoms of, 93
 treatment of, 96

Acute non-tuberculous mastoiditis, operation for, 183

Acute suppuration of the tympanic attic, 98
 complications of, 99
 symptoms of, 98
 treatment of, 99

Acute tuberculous disease of the middle ear, 103
 operation for, 105, 185
 symptoms of, 103
 treatment of, 104

Adenitis, 100

Adenoid vegetations in naso-pharynx, signs of, 35
 question of removal of, 43

Aditus ad antrum, 14

Ague, deleterious effect of, on the middle ear, 21

Air-massage, methods of employing, 63, 64

Anæmia of labyrinth, 209
 treatment of, 209

Anatomy of the ear, 1

Anterior rhinoscopy, 31

Anterior segment, 12

Antrum, anatomy of, 14
 in the foetus, 15

Artificial aids to hearing, 65

Artificial drums:
 Field's, 65
 Grüber's, 65
 Toynbee's, 65
 Yearsley's, 65

Artificial ears, 68

Atrophic pharyngitis, 126
 rhinitis, 126
 use of nasal irrigations in, 45

Attic, 6
 tympanic, acute suppuration of, 98

Aural disease, climate responsible for, 21
 forceps, 59
 polypi, 145
 speculum, 27

Auroscope, Brunton's, 64

Auscultatory tube, use of, 57
 information gained by, in inflation of middle ear, 57

Autophonia, 113

Bezold's mastoiditis, operation for, 185, 191

Bone-forceps, 197

Bony growths, 80

Bony growths, circumscribed, 81
 symptoms of, 81
 treatment of, 82

Bony outgrowths, diffused, of the external meatus, 80

Bougies, 62

Brunton's auroscope, 64

Calcareous degeneration of membrana tympani, 160

Calcareous patches, 114

Carcinoma of external ear, 204
removal of, 205

Catarrh of middle ear, 107
causes of, 107
sequelæ, 109
symptoms of, 107
treatment of, 108

Cells of mastoid process, 15

Cerebellar abscess, 171
symptoms of, 171
treatment of, 171

Cerebral abscess, 166

Cerumen, diminished secretion of, 85
excessive secretion of, 86

Ceruminous glands, diseases of, 85

Changes in tympanic membrane in chronic catarrhal otitis media, 116

Changes in nose and naso-pharynx, 119

Chilblains, 70

Cholesteatoma in middle ear, pathology of, 150
treatment of, 151

Chorda tympani nerve, 9

Chronic catarrhal otitis media, 110

Chronic Eustachian obstruction, 132
diagnosis of, 132
treatment of, 133

Chronic suppuration of the middle ear, 134
of the tympanic attic, 142
treatment of, 144

Circumcision of the stapes, 161

Circumscribed bony growths, 81
symptoms of, 81
treatment of, 82

Circumscribed inflammation of external meatus, 77
causes of, 77
course and symptoms of, 78
treatment of, 79

Climate indirectly responsible for aural disease, 21

Conduction of sound, 48

Cone of light, 14

Contraction of meatus, 155
cicatricial, 158

Crurae of stapes, 8

Curette, 179

Dangers of radical mastoid operation, 198

Deaf-mutism, 215
acquired, 216
treatment of, 216

Deafness, 37
caused by otosclerosis, 126
in regard to life assurance, 219

Deformity of external ear, plastic operations for, 67

Delstanche's rârâfacteur, 59, 63

Destruction of polypi by chromic acid, 149

Diagnostic tests for internal ear deafness, 206

Diminished secretion of cerumen, 85
treatment of, 86

Diphtheritic or croupous inflammation of external meatus, 80
treatment of, 80

Discharge in eczema of the external meatus, 38
in fracture of base of skull, 39
in furunculosis of the meatus, 38
in malignant disease of middle ear or meatus, 39
in otitis media haemorrhagica, 39
in otitis media suppurativa acuta, 38
in otitis media suppurativa chronica, 39, 136

Disease, malignant, of external ear, 204
of middle ear, 205

Diseases, chronic suppurative, of middle ear, 134
intracranial, of otitic origin, 163
of external ear, 71
of internal ear, 207
of the ceruminous glands, 85

Division of the anterior ligament of the malleus, 178
of the posterior fold of the membrane, 178
of the stapedius tendon, 178
of the tensor tympani, 177

Drum, incision of, 176

Drugs, symptoms caused by, 42

Ear-trumpets, 66

Effect of unhygienic surroundings on the ear, 22

Enlargement of posterior ends of inferior turbinates, 35

Epitheliomata, 88

Erosion of the internal carotid artery, 157
treatment of, 157

Estimation of acuteness of hearing, 45

Eustachian catheter, 53
disinfection of, 50
methods of passing, 54

Eustachian tube, acute obstruction of, 131
anatomy of, 16
bougieing of, 122

Eustachian tube, chronic obstruction of, 132
 condition of, in chronic catarrhal otitis media, 117
 internal orifice of, 6
 isthmus of, 17

Examination of meatus and tympanic membrane, 28
 of nose and naso-pharynx, 30
 of patient, 19

Excessive secretion of cerumen, 86
 symptoms of, 86
 treatment of, 87

Exostoses, 81

External ear, anatomy of, 1
 diseases of, 71
 carcinoma of, 204
 eczema of, 72
 herpes of, 72
 malignant disease of, 204
 new growths of, 73

External meatus, acute diffused inflammation of, 74
 circumscribed inflammation of, 77
 contraction of, 188
 diffused bony outgrowths of, 80
 diaphtheritic or croupous inflammation of, 80
 foreign bodies in, 89
 formation of epithelial plugs in, 84
 stenosis of, 84
 ulceration of, 79

Extradural abscess, 164
 symptoms of, 165
 treatment of, 165

Facial palsy, 99, 156
 treatment of, 100

Facial paralysis a complication of middle-ear disease, 156

Facial paralysis an indication for operation, 187

Fallopian canal, 5

Faucial tonsils, size of, 36

Fenestra ovalis, 5
 rotundum, 5

Fibromata of lobule, 73

Fibrous layer of membrana tympani, 10

Fissures of Santorini, 1

Fistulae, external and internal, 155

Footplate of stapes, 8

Foreign bodies in external meatus, 89
 inflammation caused by, 91
 removal of, 90

Frost-bites, 69
 treatment of, 69

Galton's whistle, 52

Gellé's test, 50, 128

General vertigo, 39

Glaserian fissure, 7, 9

Gouge, mastoid, 189

Goulard water, 72

Gout as cause of aural affections, 20

Gouty disturbances of the internal ear, 208
 treatment of, 209

Granulation tissue and polypus, 145

Grüber's carrier for introducing artificial tympanic membranes, 65
 snare for removal of aural polypi, 148
 speculum, 28

Guye's aprosexia, 24

Hæmatoma auris, 70
 treatment of, 71

Hæmorrhage from jugular bulb, 157

Handle of malleus, 10

Hartmann's attic cannula, 143
 probe, 153

Head-mirror, 26

Hearing, tests for, 46 *et seq.*

Henle, spine of, 3

Hyperostoses, 80

Hypertrophic rhinitis, use of nasal irrigations in, 45

Incus, anatomy of, 8
 curette, 179
 short process of, 6

Indications for intranasal treatment, 43

Indications for operation in chronic suppurative diseases, 186

Inflammation caused by foreign bodies in external meatus, 91

Inflation by catheterization, 122

Inflation in chronic catarrhal otitis media, 121

Influenza as cause of aural affections, 21

Influenza mastoiditis, operation for, 185

Injuries of internal ear, 23
 of tympanic membrane, 22

Insects in external auditory meatus, 91

Internal ear, diseases of :
 anæmia, 209
 gout, 208
 hysteria, 208.

Internal ear, diseases of :
 increase of labyrinthine pressure, 210
 inflammation of the labyrinth, 215
 leukaemic deafness, 212
 malaria, 210
 Menière's disease, 213
 primary new growths, 215
 syphilis, 207

Intracranial diseases of otitic origin, 163

Intranasal deformities, indications for removal of, 44

Isthmus of Eustachian tube, 17

Ivory or sessile growths, 83
 removal of, 83

Jugular bulb, haemorrhage from, 157

Keratosis obturans, 84
 treatment of, 85

König's rods, 45

Krause's bone punch, 182

Labyrinth, inflammation of, 215

Labyrinthine pressure, increase of, 210
 causes of, 210
 symptoms of, 211
 treatment of, 212

Lassar's ointment, 226

Lateral nystagmus, 144

Lateral sinus pyæmia, 172
 symptoms of, 173
 treatment of, 174

Lateral sinus, thrombosis of, 172

Leukaemic deafness, 212

Life assurance, influence of middle-ear disease on, 219

Light reflex of membrana tympani, 14

Long handle of malleus, 7

Lucae's probe, 63
 tuning-fork, 47

Malaria, 210

Malformations of external ear, 67

Malignant disease of the ear, 204

Malleus, anatomy of, 7
 removal of, by Delstanche's extracteur, 181
 short process of, 6

Mandl's solution, 226

Mastoid antrum, opening of, 188
 gouge, 189
 operations on, 183
 process, cells of, 15
 structure of, 17

Mastoiditis, 100
 necessity of operation for, 102

Mastoiditis treatment of, 101

Meatus, con traction of, 155

Membrana flaccida, or Shrapnell's membrane, 12

Membrana propria, 10

Membrana tympani, anatomy of, 9
 angle of, 9
 calcareous degeneration of, 160
 general shape of, 9
 layers of, 10
 light reflex of, 14
 perforation of, in chronic suppuration of the middle ear, 136
 post-suppurative changes in, 160
 residual perforation of, 160
 umbo of, 10

Menière's disease, 213
 treatment of, 214

Meningitis, 163
 symptoms of, 163
 treatment of, 164

Middle ear, acute inflammation of, 92
 anatomy of, 4
 cholesteatoma in, 150
 chronic diseases of, 158
 chronic non-suppurative diseases of, 110
 chronic sclerosis of, 125
 chronic suppurative diseases of, 134
 disease, facial paralysis a complication of, 156
 malignant disease of, 205
 operation for acute tuberculous disease of, 185
 polypi in, 145
 serous catarrh of, 107

Myringotomes, 177

Nasal douche, 61
 speculum, 31

Nausea and vomiting, 42

Necrosis of the ossicles, 152
 of the temporal bone, 153

New growths, 88
 of external ear, 73

Notch of Rivini, 11

Nystagmus, 43

Obstruction of Eustachian tube, 130

Occupation and aural affections, 22

Opening of the mastoid antrum, 188
 preliminary measures, 189

Operation for acute tuberculous disease of the middle ear, 185
 for influenzal mastoiditis, 185
 for spongy pedunculated growths, 82

Operation in acute non-tuberculous mastoiditis, 183
 in Bezold's mastoiditis, 185, 191
 radical mastoid, 193

Operation, indications for, in chronic suppurative diseases:
 acute exacerbations in chronic discharge, 187
 cholesteatomatous degeneration, 187
 contraction of the external meatus, 188
 facial paralysis, 187
 lateral vertigo on syringing, 187
 persistent mastoid pain, 187

Operations, minor, 176
 in suppurative otitis, 179
 on the mastoid process, 183

Organ of Corti, 47

Ossicles, 6
 indications for removal of, 180
 necrosis of, 152

Ossiculectomy, 179
 preliminary preparations for, 180

Ostium, 17

Otitis cerebral abscess, 166
 symptoms of, 167
 treatment of, 170

Otitis haemorrhagica acuta, 106
 symptoms of, 106
 treatment of, 107

Otitis interna, 215

Otitis media chronica adhesiva, 110
 condition of tympanic membrane in, 114
 course and symptoms of, 111-119
 diagnosis of, 119
 operation for, 125
 treatment of, 120
 tuning-fork tests in early stages of, 117
 vertigo a late symptom of, 118

Otitis media suppurativa chronica, 134
 causes of, 134
 complications of, 144
 course of, 142
 discharge in, 136
 perforation of membrana tympani in, 136
 of Shrapnell's membrane in, 137, 140, 141, 153
 of the membrana propria in, 136, 137
 signs and symptoms of, 135

Oto-massage, 124

Otomycosis, 76
 symptoms of, 76

Otomycosis, treatment of, 77

Otosclerosis, 125
 condition of membrana tympani in, 128
 course and symptoms of, 126
 deafness caused by, 126, 127
 oto-massage to be employed in, 129

paracusis Willisii in, 127
 pathological changes in, 125, 126
 tinnitus in, 127
 treatment of, 129
 tuning-fork tests in, 128

Pain, 37

Papillomata, 88

Paracentesis, 176

Paracusis loci, 113

Paracusis Willisii, 113
 in otosclerosis, 127

Paralysis, facial, 156

Patient, aspect of, 23
 history of, 25
 special examination of, 26

Perforation of membrana tympani in chronic suppuration of the middle ear, 136
 in posterior superior quadrant, 140
 of membrana propria, 136, 137
 of Shrapnell's membrane, 137, 140, 141

Pinna, 1

Plastic operations for deformity of external ear, 67

Pneumatic speculum, Siegel's, 59

Pneumo-massage. See air-massage

Politzerization, 52

Politzer's bag, 91

Polypi of middle ear, 145
 destruction of, by chromic acid, 149
 Grüber's snare for removal of, 148
 pathology and histology of, 147
 removal of, by blunt curette, 149
 treatment of, 148

Posterior rhinoscopy, 32

Posterior segment, 12

Precautions to be observed in removal of foreign bodies in external meatus, 99

Primary new growths of the internal ear, 215

Processus brevis, 7
 gracilis, 7

Promontory, 6

Protruding ears, surgical treatment of, 68

Pyramid, 6

Radical mastoid operation, 193-203
 after-treatment, 200
 clinical results of, 203
 dangers of, 198
 plastic operations after, 200
 preliminary preparations, 193

Rarefaction of air in external meatus, 123

Removal of foreign bodies in external meatus, 90

Residence in tropics, effect of, on middle-ear disease, 21

Retractor, 188

Rheumatism as cause of aural affections, 21

Rhinoscopy, anterior, 31
 posterior, 32

Rigors, importance of, 43

Rinne's test, 50, 128

Rosenmüller's fossa, 17

Serous catarrh of the middle ear, 107
 causes of, 107
 sequelæ, 109
 symptoms of, 107
 treatment of, 108

Serous cysts of auricle, 73
 treatment of, 73

Sessile growths, 83

Short process of incus, 6
 of malleus, 6

Shrapnell's membrane, 12, 13
 perforation of, in otitis media
 suppurativa chronica, 137

Siegel's speculum, 30, 59

Spine of Henle, 3

Spongy pedunculated growths, operation for, 82

Stapedius muscle, 6

Stapes, anatomy of, 8
 circumcision of, 161
 crurae of, 8
 footplate of, 8

Stenosis of external meatus, 84
 treatment of, 84

Subjective noises, 41

Sulcus tympanicus, 11

Suspensory ligament, 8

Suppurative disease of the middle ear
 in regard to life assurance, 220

Suppurative otitis, operations in, 179

Syphilis of the internal ear, 207
 treatment of, 208

Syringing for removal of pus, 59
 for suppurative disease, 58

Tegmentum tympani, 4

Temporal bone, necrosis of, 153

Testing with the human voice, 45
 with tuning-fork, 46

Tests for hearing:
 Galton's whistle, 52
 Gellé's, 50
 Rinne's, 50
 watch or acoumeter, 50
 Weber's, 49
 Wolff's, 46

Thrombosis of lateral sinus, 172

Thudichum's nasal speculum, 31

Tinnitus, 41
 as a cause of suicide, 42
 as a symptom of chronic catarrhal
 otitis media, 113
 in chronic catarrhal otitis media,
 113
 in otosclerosis, 127
 in regard to life assurance, 219
 operative treatment of, 130

Tuning-fork, directions for using,
 47
 Lucæ's, 46, 47

Tympanic attic, acute suppuration of,
 98
 chronic suppuration of, 142

Tympanic cavity, anatomy of, 4
 walls of, 6

Tympanic membrane. See Membrana tympani
 appearance of, in chronic catarrhal
 otitis media, 114
 calcareous degeneration of, 114

Tympanic orifice of Eustachian tube,
 16

Tympanum, contents of, 6

Ulceration of external meatus, 79

Urbantschitsch's exercises of hearing,
 216-218

Vapours, use of, in chronic catarrhal
 otitis media, 123

Vertigo, general, 39
 in regard to life assurance, 219
 on syringing, 144
 specific aural, 40

Vomiting, 42

Weber's test, 49

Wolff's tests for hearing, 46



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